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NATIONAL HEALTH INSURANCE PROPOSALS

Provisions of Bills Introduced in the 93rd Congress as of October 1973

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By

Saul Waldman

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration
Office of Research and Statistics

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FOREWORD

In recent years, the need for a national plan to help individuals and families finance the cost of medical care has received increasing attention. Consideration of alternative ways to finance medical care has been made more urgent by sharply rising costs of such care. Behind the rising costs are a variety of causes: innovations in medical technology, new diagnostic techniques, new therapies, new drugs, higher outlays for medical manpower and equipment.

Faced with persistent rises in medical care prices stemming from such causes, existing methods of financing medical care are being questioned. Costs are currently covered by a combination of private efforts through out-of-pocket and health insurance premium payments, plus a diversity of government programs at the Federal, State, and local levels. Thus proposals for some form of national health insurance represent, in large part, efforts to reorganize the methods of financing medical care costs--efforts which might (in some cases but not in others) result in larger overall outlays.

Within this context, opinions vary widely concerning the most desirable approach. Proposals range from implementation through a single plan to a combination of plans with existing programs absorbed or continued. Financing mechanisms for the proposals suggest various private sources, Federal funds, State funds, and mixtures of all of these. Various options are also offered in the administration of the proposals, including the private sector, Federal and State governmental agencies, or combinations of private and public organizations. Various ways of permitting voluntary participation are incorporated in some of the proposals.

This report updates part of the August 1971 report, *Analysis of Health Insurance Proposals Introduced in the 92d Congress*, prepared for the use of the Committee on Ways and Means by the Social Security Administration's Office of Research and Statistics. It describes the provisions and features of the various plans introduced to date in the 93rd Congress, but does not include cost estimates as was done in the earlier report. Prepared by Saul Waldman of the ORS Division of Health Insurance Studies, this study offers a common analytical framework for all of the proposals now before the Congress. William J. Sobaski reviewed and made significant contributions to the report. As a summary reference it should be useful for many analytical purposes as consideration of alternative ways to finance medical care in the United States continues.

John J. Carroll
Assistant Commissioner for Research and Statistics.

November 1973

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INTRODUCTION

This report includes all of the 13 national health insurance bills introduced in the 93rd Congress as of October 1973. For this report, a national health insurance plan is defined as one which would at least (1) establish a plan by law, or provide substantial incentives for its voluntary establishment, (2) use some type of insurance mechanism, (3) potentially affect the majority of the population, and (4) specify the type of medical services to be included.

To aid in comparisons, the plans have been grouped according to their general approach as follows:

(1) Mixed public and private plans

(2) Mainly public plans

(3) Tax credit plans

(4) Catastrophic protection plans

The classification of the proposals into these groups necessarily involves a degree of arbitrariness. Differentiating between the "mixed public and private plans" and the "mainly public plans" presented relatively few problems because the two in the latter group involve almost complete government financing and administration, while all those in the former group use both the private and governmental sectors for financing or administration, or both.

On the other hand, the terminology "tax credit plans," while describing clearly the nature of the approach, refer to proposals which could well be termed "mainly private."

Finally, all the "catastrophic protection plans" do in fact provide insurance against the costs of catastrophic illness for the general population, but (except the first Long bill) also provide special basic and catastrophic medical assistance for the poor.

Table A lists the bills by name (citation) and number according to their first sponsor in the House and Senate. Announced support of bills by major national organizations is indicated. The table also compares the bills with those introduced in the 92d Congress; most of the bills are identical to or modifications of bills in the last session. (All of the bills with national organizational support have been modified.)

To facilitate analysis, the provisions of all the bills (regardless of their approach) have been presented according to a uniform set of subject headings. While there are some exceptions in format, the following subjects are covered for all plans:

(1) General concept and approach
(2) Coverage of the population
(3) Benefit structure
(4) Administration
(5) Relationship to other government programs
(6) Financing
(7) Standards for providers of service
(8) Reimbursement of providers of service
(9) Delivery and resources

Many of the bills include provisions specifically designed to effect changes in the methods of delivery of health care services and/or to increase the supply of health manpower and resources. These specific provisions are included in the last category. Of course other provisions, especially the standards for providers and the reimbursement methods, would often have significant effects on health delivery and resources.

Many of the plans have established the standards for providers of service to participate in the program by reference to the standards used in the present Medicare law. A description of these Medicare standards is shown on page 117.

Summary charts describing the major features of the proposals follow. The chart for the Catastrophic Illness Insurance Act, S. 1416, has been omitted since it is identical to the catastrophic illness insurance part of S. 2513, introduced by Senators Long and Ribicoff.

Bills Introduced After October

A new bill, received too late to be included in this report, is the *National Comprehensive Health Care Benefits Act of 1973*, introduced on November 9, 1973, by Representative Harley O. Staggers of West Virginia, as H.R. 11345.

The bill would require employers to provide health insurance coverage with specified benefits for their employees. The employer would pay 75 percent of the premium cost. In addition, States would arrange pools of private health insurance carriers to make available similar coverage to self-employed individuals and others (who are not covered by an employer plan). The covered persons would pay the pool premium.

The bill also provides a plan for the poor under which health insurance would be provided for individuals and families with incomes under specified levels. The benefits would be the same as under the employer plan. The cost would be financed by premium contributions, graduated according to family income (but no contributions by the lowest income group), with the balance paid from Federal general revenues.

The aged would remain under the Medicare program, but would receive additional benefits provided by the bill which are not covered by Medicare.

The States would establish health care commissions which would supervise the employer plans and the pools, administer the plan for the poor, and enforce cost and quality controls for providers of medical services. The bill also includes provisions to encourage the development and use of health maintenance organizations.

A second new bill received too late for inclusion is the *Health Rights Act of 1973*, introduced on November 29, 1973, by Senators Hugh Scott of Pennsylvania and Charles Percy of Illinois, as S. 2756. The bill is a modification of the one they introduced in 1971.

The proposal consists of two parts. The inpatient health care program would provide catastrophic protection for institutional services (hospital, nursing home and home health) with the amount of the benefit payment based on family income and size and the amount of the institution's charges. The proposal would be financed by the payroll tax now levied for the Medicare hospital insurance program (which would be abolished) and appropriations from Federal general revenues, to the extent needed, are also authorized.

The supplementary medical insurance program would provide a range of outpatient benefits, subject to a deductible which varies by family income and size. The cost would be financed by family premium payments, graduated according to the family size and income (with no contribution by the lowest income group), and the balance from Federal general revenues. Both parts of the proposal would be administered by private insurance carriers or other public or private administrative organizations under contract with the Department of Health, Education, and Welfare, which would establish the regulations and review the program.

The bill authorizes loans and grants to encourage the development of health maintenance organizations.

TABLE A.--LISTING OF NATIONAL HEALTH INSURANCE BILLS INTRODUCED IN THE 93rd CONGRESS, BY TYPE OF PROPOSAL IN ORDER OF BILL NUMBER 1/

Type and name of bill	House		Senate		Support by national organization	Comparison with bills introduced in the 92d Congress 2/
	First sponsor	Bill number	First sponsor	Bill number		
Mixed public and private						
The National Health Care Services Reorganization and Financing Act...	Ullman.....	H.R. 1.....	None.....	None.....	American Hospital Association.	Modified.
National Health Insurance Partnership Act of 1971.....	Railsback.....	H.R. 2618.....	None.....	None.....	.....	Identical to the previous Byrnes bill introduced on behalf of the Administration.
National Health Care Act of 1973....	Burleson.....	H.R. 5200.....	McIntyre.....	S. 1100.....	Health Insurance Association of America.	Modified.
National Health Care Act of 1973....	Fuqua.....	H.R. 559.....	None.....	None.....	.....	Identical to previous Burleson bill.
National Health Insurance and Health Services Improvement Act of 1973.....	None.....	None.....	Javits.....	S. 915.....	.....	Identical.
Mainly public						
The Health Security Act.....	Griffiths.....	H.R. 22.....	Kennedy.....	S. 3.....	AFL-CIO, Committee for National Health Insurance.	Modified.
National Health Insurance Act.....	Dingell.....	H.R. 33.....	None.....	None.....	.....	Identical.
Tax credits						
Health Care Insurance Act of 1973...	Fulton-Broyhill.	H.R. 2222.....	Hartke.....	S. 444.....	American Medical Association.	Modified.
Health Care Insurance Act of 1973...	Ashbrook.....	H.R. 288.....	None.....	None.....	.....	Identical to previous Fulton-Broyhill bill.
Catastrophic protection						
National Catastrophic Illness Protection Act of 1973.....	Roe.....	H.R. 1054.....	Beall.....	S. 587.....	.....	Identical to previous Hogan bill, but introduced first by Roe.
National Health Care Program.....	Saylor.....	H.R. 1916.....	None.....	None.....	.....	Identical to previous Hall bill. 3/
Catastrophic Health Insurance and Medical Assistance Reform Act.....	None.....	None.....	Long-Ribicoff...	S. 2513.....	.....	Modification of S.1376 and additional provisions. 4/
Catastrophic Illness Insurance Act..	None.....	None.....	Long.....	S. 1416.....	.....	Modified. 4/

1/ Some exceptions made to order of bill number for certain similar bills.
2/ The Pell-Mondale bill, introduced in the 92d Congress, has not been reintroduced in the present session. See Introduction for information on the new Scott-Percy bill.
3/ Representative Hall is not a member of the 93rd Congress.
4/ S. 1416 is a modification of S. 1376 of the 92d Congress. S. 2513 includes the provisions of S. 1416 and additional provisions relating to medical assistance and certification of private health insurance.

Mixed public and private--ULLMAN BILL

Subject	Provisions	
General concept and approach	A 3-part program covering the entire population: (1) plan requiring employers to provide private coverage for employees, (2) a plan for individuals, and (3) federally contracted coverage for the poor and aged. State establishes a health care plan, supervises carriers and insurers, and promotes a system of chartered health care corporations (HCC).	
	Private plans	Plan for low income and aged
Coverage of the population	Employees (and their families) of employers subject to the social security tax. Also, individuals who elect coverage.	Low-income and medically indigent families, and aged persons.
Benefit structure	Benefits phased in over 5-year period. Final benefits: Institutional services: Hospital: 90 days, $5 copayment per day. Skilled nursing facility: 30 days, $2.50 copayment per day. Nursing home: 90 days, $2.50 copayment per day. Personal services: Physicians: 10 visits per year, $2 copayment per visit. Laboratory and X-ray: 20 percent coinsurance. Home health services: 100 visits per year, $2 copayment per visit. Dental services: Children age 7-12: 1 exam per year, other services, 20 percent coinsurance. Other services and supplies: Prescription drugs: Limited to specified conditions, $1 per prescription. Medical equipment and appliances and ambulance service: 20 percent coinsurance. Eyeglasses: Children to age 12, 1 set per year, 20 percent coinsurance. Catastrophic coverage: Payable when certain noncovered expenses reach a specified limit, which varies by family income and age; would remove the cost sharing on all benefits and the limitation on number of hospital days and physicians' visits.	
Administration	Administered by private insurance carriers under State supervision, according to Federal guidelines.	Federal Government would contract with private insurance carriers who issue policies to eligible persons.
Relationship to other Government programs	Medicare: Abolished. Medicaid and other assistance programs: Would not pay for covered services. Other programs: Mostly not affected.	
Financing	Employee-employer premium payments, with employer paying at least 75 percent. Federal subsidy of premium for low-income workers and certain small employers, and 10 percent subsidy for HCC enrollees. Individuals pay own premium.	Financed in part by premium payments by medically indigent, but with no premium for lowest income group. Balance of cost financed by Federal general revenues and the payroll taxes of the present Medicare program.
Standards for providers of services	All institutions and HCC's must meet Medicare standards. Skilled nursing facilities must be under supervision of a hospital medical staff or have its own organized staff. Use of paramedical personnel must meet Federal standards. All providers and HCC's must establish systems of peer review, medical audit and other procedures to meet Federal-State requirements on quality and utilization of services.	
Reimbursement of providers of services	Institutions and HCC's: State commission would prospectively approve charges based on review of budget and schedule of proposed charges. Physicians and other professionals: Reasonable fee, salaries, or other compensation, as approved by State commission.	
Delivery and resources	State health commission: Establishes a State health plan, including provisions for regulation of providers and insurance carriers. Takes responsibility for health planning and must approve, in advance, proposed capital expenditures of providers. Health care corporations: State commissions would incorporate system of HCC's, approved to operate in designated geographical areas. HCC must furnish all covered services through its own facilities or affiliated providers (and permit all qualified practitioners to furnish services for it). Would be required to hold open enrollment for public and eventually offer services on a per capita basis. Federal grants provided for HCC's for planning, development, outpatient centers, medical and data equipment, and to cover initial operating deficits.	

Mixed public and private--RAILSBACK BILL

Subject	Provisions	
General concept and approach	A 2-part national health insurance plan covering the population under age 65: (1) required employer plan providing private insurance for employees and (2) federally operated family health insurance plan (FHIP) for low-income families with children. Provisions to encourage use of health maintenance organizations.	
	Employer-employee plan	FHIP plan
Coverage of the population	Employers required to provide coverage for employees and their families. Special insurance pools for small employers, self-employed, and other individuals.	Low-income families with children who meet specified income and asset levels.
Benefit structure	All services subject to $100 annual deductible per person and 25 percent coinsurance, except as indicated. Institutional services: Hospital: 2-day deductible and 25 percent coinsurance for room and board per year. Other services subject to annual deductible and coinsurance. Personal services: Physicians: Annual deductible and coinsurance. Well-baby care: Up to age 5 without cost sharing. Laboratory and X-ray: Annual deductible and coinsurance. Other services and supplies: Medical appliances: Annual deductible and coinsurance.	No cost sharing for lowest income group; for others, according to family income. Institutional services: Hospital: 30 days of care. Extended-care facility: 3 days substituted for 1 hospital day. Personal services: Physicians: 8 visits per year (no limit in hospital). Home health services: 7 days substituted for 1 day of hospital care. Laboratory and X-ray. Family planning, maternity care, and well-baby care. Other services and supplies: Medical supplies and appliances.
Administration	Private insurance carriers. HEW determines if plan is qualified.	Administered by DHEW.
Relationship to other Government programs	Medicare: Continues to operate. Medicaid: Limited to aged, blind, and disabled persons. Other programs: Most not affected.	
Financing	Employee-employer premium payments with employer paying 75 percent (65 percent for 1st 2-1/2 years of program). Employers with high premium costs get subsidy payments for up to 10 employees.	Financed in part by premiums paid by enrollees, graduated according to income; no premium for lowest-income group. Balance of costs paid from Federal general revenues.
Standards for providers of services	Same as Medicare.	
Reimbursement of providers of services	Hospitals and other institutions: Reasonable cost of services (same as Medicare). Physicians: Reasonable charges (same as Medicare). Health maintenance organizations: Per capita rate.	
Delivery and resources	Health maintenance organizations: Would be available as an option under all plans.	

Mixed public and private--BURLESON-McINTYRE BILL

Subject	Provisions	
General concept and approach	A 3-part voluntary health insurance plan: (1) an employee-employer plan, (2) plan for individuals, and (3) a State plan for the poor. All plans administered through private insurance carriers and provide same benefits. Supported by the Health Insurance Association of America.	
	Private plans	State plan
Coverage of the population	Employee-employer plan includes employees (and their families) of employers who voluntarily elect coverage under a qualified plan. Individual plan includes persons who voluntarily elect.	For poor and uninsurable persons.
Benefit structure	Benefits phased-in over a 10-year period for private plans and 5 years for State plan. Final benefits as follows: Institutional services: Hospital: 300 days; $5 per day. Skilled nursing facility: 180 days; $2.50 copayment per day. Personal services: Physicians: $2 copayment per visit. Dentists: 1 exam each year; other services 20 percent coinsurance. Home health services: 270 days; $2.50 copayment per day. Laboratory and X-ray: No cost sharing. Other health professionals: 20 percent coinsurance. Other services and supplies: Medical appliances: 20 percent coinsurance. Eyeglasses: No coinsurance before age 19; 50 percent after age 19. Prescription drugs: $1 copayment per prescription.	
	For employee-employer plan, annual limit for all cost sharing of $1,000 per family. For individual plans, no limit on cost sharing.	No cost sharing for lowest income families; for others, cost sharing according to family income.
Administration	Insurance administered by private carriers under State supervision. Treasury Department determines tax status of plan.	Insurance administered by private carriers under agreement with the State. Regulations for program established by DHEW.
Relationship to other Government programs	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services under programs. Other programs: Most not affected.	
Financing	For employee-employer plan, premium paid by employers and employees, as arranged between them, but contributions of low-income workers limited according to their wage level. For individual plan, policyholder pay entire premium. Employees and individuals who itemize deductions can take entire premium as deduction on income tax return. Employers can take their entire premium as normal business deduction as under present law (but contributions to nonqualified plans would not be deductible).	No premium required for lowest income group; for others, premium paid by enrollees, varying according to family income. Federal and State governments pay balance of costs from their general revenues, with Federal share 70 to 90 percent, according to State.
Standards for providers of services	Same as Medicare.	
Reimbursement of providers of services	Hospitals and other institutions: Prospectively approved rates for various categories of institutions. Hospitals prepare budgets and schedule of charges which are reviewed by a State commission which approves or disapproves charges, subject to DHEW review of rate levels. Physicians and dentists: Reasonable charges, based on customary and prevailing rates.	
Delivery and resources	Health planning: Increased funding for State and local planning agencies. Planning agency approval required for projects receiving Federal assistance. Health maintenance organizations: Must be made available as an option to persons enrolled in State plan and employee-employer plans. Ambulatory health centers: Grants, loans, and loan guarantees for construction and operation of centers. Health manpower: Increases loans and grants for students, with special provisions for shortage areas.	

Mixed public and private--FUQUA BILL

Subject	Provisions	
General concept and approach	A 3-part voluntary health insurance plan: (1) an employee-employer plan, (2) plan for individuals, and (3) a State plan for the poor. All plans administered through private insurance carriers and provide same benefits.	
Coverage of the population	Private plan Employee-employer plan includes employees (and their families) of employers who voluntarily elect coverage under a qualified plan. Individual plan includes persons who voluntarily elect.	State plan For poor and uninsurable persons.
Benefit structure	Benefits phased-in over a 6-year period for private plans and 4 years for State plan. Final benefits as follows: Institutional services: Hospital: 300 days; $10 copayment for 1st day, then $5 per day. Skilled nursing facility: 180 days; $2.50 copayment per day. Personal services: Physicians: $2 copayment per visit. Dentists: 1 exam each year; other services 20 percent coinsurance. Home health services: 270 days; $2.50 copayment per day. Laboratory and X-ray: No cost sharing. Other health professionals: 20 percent coinsurance. Other services and supplies: Medical appliances: 20 percent coinsurance. Eyeglasses: No cost sharing before age 19; 50 percent after age 19. Prescription drugs: $1 copayment per prescription.	
	For employee-employer plan, annual limit for all cost sharing of $1,000 per family. For individual plans, no limit on cost sharing.	No cost sharing for lowest income families; for others, cost sharing according to family income.
Administration	Insurance administered by private carriers under State supervision. Treasury Department determines tax status of plan.	Insurance administered by private carriers under agreement with the State. Regulations for program established by DHEW.
Relationship to other Government programs	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services under programs. Other programs: Most not affected.	
Financing	For employee-employer plan, premium paid by employers and employees, as arranged between them. For individual plan, policyholder pays entire premium. Employees and individuals who itemize deductions can take entire premium as deduction on income tax return. Employers can take their entire premium as normal business deduction as under present law (but for nonqualified plans they would not be fully deductible).	No premium required for lowest income group; for others, premium paid by enrollees, varying according to family income. Federal and State governments pay balance of costs from their general revenues, with Federal share 70 to 90 percent, according to State.
Standards for providers of services	Same as Medicare.	
Reimbursement of providers of services	Hospitals and other institutions: Prospectively approved rates for various categories of institutions. Hospitals prepare budgets and schedule of charges which are reviewed by a State commission for approval or disapproval of charges, subject to DHEW review of rate levels. Physicians and dentists: Reasonable charges, based on customary and prevailing rates.	
Delivery and resources	Health planning: Increased funding for State and local planning agencies. Planning agency approval required for projects receiving Federal assistance. Health maintenance organizations: Must be made available as an option to persons enrolled in State plan and employee-employer plans. Ambulatory health centers: Grants, loans, and loan guarantees for construction and operation of centers. Health manpower: Increases loans and grants for students, with special provisions for shortage areas.	

Mixed public and private--JAVITS BILL

Subject	Provisions
General concept and approach	Program based on expansion of Medicare program to general population. Administered by Federal Government and financed by payroll taxes and Federal general revenues. Also includes option for alternative coverage under private insurance plans.
Coverage of the population	All U.S. residents.
Benefit structure	Benefits same as Medicare, plus additional benefits. Most services (except institutional) subject to present Medicare "Part B" cost sharing of $60 annual deductible per person and 20 percent coinsurance. Institutional services: Hospital: 90 days; $72 deductible, $18 copayment per day after 60th day. Skilled nursing facility: 100 days; $9 copayment per day after 20th day. Personal services: Physicians: Part B cost sharing. Physical checkups: 20 percent coinsurance Dentists: For children under 8; 20 percent coinsurance. Home health services: 100 visits plus 100 post-hospital visits. Laboratory and X-ray: Part B cost sharing. Other health professionals: Part B cost sharing. Other services and supplies: Medical appliances: Part B cost sharing. Prescription drugs: For chronic conditions, $1 charge per prescription.
Administration	Federal Government: Similar to Medicare. DHEW would have general administrative responsibility. Private insurance carriers (or quasi-governmental corporations) would handle claims and pay providers. Employer-employee plans: Employers may elect out of the Government program by establishing an approved private insurance plan providing superior benefits. Carrier plans: Individuals may elect out by purchasing approved private insurance providing equivalent benefits.
Relationship to other Government programs	Medicare: Absorbed by program. Medicaid and other assistance programs: Would not pay for services covered under proposal. Other programs: Most not affected.
Financing	Tax on payroll and self-employment income plus Federal general revenues. Tax rates: (a) 3.3 percent of earnings for employers, employees, and self-employed; (b) general revenue contribution equal to 1/2 of total tax receipts. Earnings subject to tax: 1st $15,000 of earnings for employee and self-employed; total payroll for employers. Employment subject to tax: Workers under social security, plus Federal, State, and local government employees. Employer-employee plans: Employers and employees exempt from regular payroll tax. Employer pays at least 75 percent of cost of private plan.
Standards for providers of services	Same as Medicare. Additional standards may be established for physicians concerning continuing education, national licensing, and qualifications for major surgery and other specialists' services.
Reimbursement of providers of services	Same as Medicare for 1st 2 years of program; afterward, new payment methods may be established, based on a study required under bill. In interim, hospitals and nursing homes receive reasonable costs of services; physicians, dentists, and suppliers receive appropriate and reasonable charges. Comprehensive health service systems paid reasonable cost or per capita rate for enrolled members.
Delivery and resources	Comprehensive health service systems: DHEW can contract with comprehensive systems to provide health care to enrolled population. Systems must provide all covered services, preventive services, health education, and must train paramedical health personnel. Loans, grants, and technical assistance provided for the development, operation, and construction of comprehensive systems.

Mainly public--GRIFFITHS-KENNEDY BILL

Subject	Provisions
General concept and approach	A program providing broad benefits, administered by Federal Government and financed by payroll taxes and Federal general revenues. Supported by Committee for National Health Insurance and AFL-CIO.
Coverage of the population	All U.S. residents.
Benefit structure	Benefits with no limitations, except as noted, or cost sharing. Institutional services: Hospital. Skilled nursing facility: 120 days of care. Personal services: Physicians. Dentists: For children under age 15; scheduled extension to age 25; eventually to entire population. Home health services. Other health professionals. Laboratory and X-ray. Other services and supplies: Medical appliances and ambulance services. Optometrists and eyeglasses. Prescription drugs: As needed for chronic illness and other specified diseases.
Administration	Federal Government: Special board in DHEW, with regional and local offices to operate program.
Relationship to other Government programs	Medicare: Abolished. Medicaid and other assistance programs: Would not pay for covered services. Other programs: Most not affected.
Financing	Tax on payroll, self-employed, and unearned income, and Federal general revenues. Tax rates: (a) 1.0 percent on employee wages and unearned income, (b) 3.5 percent for employers, (c) 2.5 percent for self-employed, and (d) Federal general revenues equal to total receipts from taxes. Income subject to tax: 1st $15,000 annually for individuals; total payroll for employers. Employment subject to tax: Workers under social security, plus Federal, State, and local government employment. State and local governments do not pay employer tax.
Standards for providers of services	Same as Medicare, but with additional requirements: Hospitals cannot refuse staff privileges to qualified physicians. Skilled nursing facilities must be affiliated with hospital which would take responsibility for quality of medical services in home. Physicians must meet national standards; major surgery performed only by qualified specialists. All providers: Records subject to review by regional office. Can be directed to add or reduce services, provide services in a new location, and to establish linkages with other providers.
Reimbursement of providers of services	National health budget established and funds allocated, by type of medical services, to regions and local areas. Hospitals and nursing homes: Would receive annual predetermined budget, based on reasonable cost. Physicians, dentists, and other professionals: Methods available are fee-for-service based on fee schedule, per capita payment for persons enrolled, and (by agreement) full- or part-time salary. Payments for fee-for-service may be reduced if payments exceed estimates. Health maintenance organizations and medical society foundations: Per capita payment for all services (or budget for institutional services). Can retain all or part of savings.
Delivery and resources	Health planning: DHEW responsible for health planning, in cooperation with State planning agencies. Priority to be given to development of comprehensive care on ambulatory basis. Health resources development fund: Will receive, ultimately, 5 percent of total income of program, to be used for improving delivery of health care and increasing health resources. Health maintenance organizations: Grants for development, loans for construction, and payments to offset operating deficits. Manpower training: Grants to schools and allowances to students for training of physicians for general practice and shortage specialties, other health occupations, and development of new kinds of health personnel.

Mainly public--DINGELL BILL

Subject	Provisions
General concept and approach----------	Program providing health benefits, administered at Federal, State, and local levels and financed by payroll taxes.
Coverage of the population----------	All U.S. residents.
Benefit structure----------	Benefits with no cost sharing or limitations, except as noted. Institutional services: Hospital: 60 days of care. Personal services: Physicians. Dentists. Home health services. Laboratory and X-ray. Other health professionals. Other services and supplies: Medical appliances and eyeglasses. Prescription drugs: Unusually expensive drugs. Specified benefits may be delayed in a State if resources are inadequate.
Administration----------	Federal Government: Special board in DHEW with overall supervision of program. State: Under contract with Federal Government, would establish State plan to operate program at the local level.
Relationship to other Government programs--	Medicare: Continues to operate, but study to be made of methods of incorporating it into the national plan. Medicaid and other assistance programs: Would not pay for services under the national plan. Other programs: Most not affected.
Financing----------	Tax on wage and self-employment income similar to social security tax. Total tax for employers and employees combined would be 4 percent.
Standards for providers of services--------	Must meet State standards. If no State standards, they would be established by national board.
Reimbursement of providers of services-----	Hospitals and other institutions: Reasonable cost of services subject to a maximum rate. Physicians and other professionals: Fee for service (based on fee schedule), per capita (for persons enrolled with a practitioner), or salary.
Delivery and resources----------	Grants to students and educational institutions for training in health occupations.

Tax credits--FULTON-BROYHILL--HARTKE BILL

Subject	Provisions
General concept and approach	Would provide credits against personal income taxes to offset the premium cost of qualified private health insurance providing specified benefits. Also, would require employers to provide qualified policies to retain favorable tax treatment. Supported by American Medical Association.
Coverage of the population	All U.S. residents, on voluntary basis.
Benefit structure	Tax credits of 10 to 100 percent of cost of qualified health insurance policy, depending on annual tax payments. Voucher certificates issued to persons with little or no tax liability. Institutional services: Hospital: 60 days of care; $50 deductible per stay. Skilled nursing facility: Substituted for hospital days on 2 for 1 basis; $50 deductible per stay. Personal services: Physicians: 20 percent coinsurance. Dental care: Initially for children age 2-6. Later extended up to age 17. Home health services: 20 percent coinsurance. Laboratory and X-ray: 20 percent coinsurance. Other services and supplies: Ambulance services: 20 percent coinsurance. Catastrophic coverage: Unlimited hospital days, an additional 30 days in a skilled nursing facility, prosthetic devices, and blood (after 3 pints) covered after corridor deductible (out-of-pocket payment) which varies according to income. Total coinsurance for physicians, laboratory and X-ray combined limited to $100 per family; separate limit of $100 for hospital outpatient, home health, and ambulance; and separate limit of $100 for dental care. Medicaid program would pay all cost sharing for cash assistance recipients.
Administration	Private insurance carriers issue health insurance policies. State insurance departments certify carriers and qualified policies. DHEW issues voucher certificates. A new Federal board establishes standards for program.
Relationship to other Government programs	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services under program. Other programs: Most not affected.
Financing	Tax credits financed from Federal general revenues. Employers must provide qualified policies as a condition of taking the full premium cost as a normal business deduction.
Standards for providers of services	No provisions.
Reimbursement of providers of services	Usual and customary charges.
Delivery and resources	No provisions.

Tax credits--ASHBROOK BILL

Subject	Provisions
General concept and approach	Would provide credits against personal income taxes to offset the premium cost of qualified private health insurance providing specified benefits. Also would require employers to provide qualified policies to retain favorable tax treatment.
Coverage of the population	All U.S. residents, on voluntary basis.
Benefit structure	Tax credits of 10 to 100 percent of cost of qualified health insurance policy, depending on annual tax payments. Voucher certificates issued to persons with little or no tax liability. Institutional services: Hospital: 60 days of care; $50 deductible per stay. Extended-care facility: Substituted for hospital days on 2 for 1 basis; $50 deductible per stay. Personal services: Physicians: 20 percent coinsurance. Laboratory and X-ray: 20 percent coinsurance. Catastrophic coverage: Additional hospital days, 30 nursing facility days, and prosthetic devices covered after corridor deductible (out-of-pocket payment) which varies according to income. Total coinsurance (for physicians, laboratory and X-ray) limited to $100 per family. Additional limit of $100 for hospital outpatient services.
Administration	Private insurance carriers issue policies. State insurance departments certify carriers and qualified policies. DHEW issues voucher certificates. The new Federal board establishes standards for program.
Relationship to other Government programs	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services under program. Other programs: Most not affected.
Financing	Tax credits financed from Federal general revenues. Employers must provide qualified policies as a condition of taking the full premium cost as a normal business deduction.
Standards for providers of services	No provisions.
Reimbursement of providers of services	Usual and customary charges.
Delivery and resources	No provisions.

Catastrophic protection--ROE-BEALL

Subject	Provisions
General concept and approach	Program which would pay medical expenses when they exceed a specified amount. Administered by private insurance companies under State supervision and financed by private premium payments and Federal subsidy.
Coverage of the population	All U.S. residents, on voluntary basis.
Benefit structure	All services eligible as medical expense deductions under the income tax law may be covered after family medical expenses exceed a specified amount (the deductible) which varies according to family income and size. There is no deductible for low-income families but the deductible rises rapidly as income increases. Expenses paid by other private insurance or government programs can be counted toward the deductible.
Administration	Private insurance carriers would issue and administer the insurance policies. Each State would design and establish a plan. DHEW would establish regulations for the program.
Relationship to other Government programs	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services covered under the program. Other programs: Most not affected.
Financing	Policyholders would pay premium. Premium rate: DHEW would determine actuarial value of policies, but could set a premium rate lower than the actuarial value to encourage widespread enrollment. It would pay carriers (from general revenues) the difference between the actuarial value and the premium rate. Reinsurance: DHEW would arrange a reinsurance mechanism. The carrier would pay the reinsurance premiums.
Standards for providers of services	No provisions.
Reimbursement of providers of services	No provisions.
Delivery and resources	No provisions.

Catastrophic protection--SAYLOR BILL

Subject	Provisions	
General concept and approach	A 2-part program: (1) State plan of health insurance for the poor providing basic and catastrophic coverage and (2) Federal program of catastrophic protection for the rest of the population.	
	Poor	General population
Coverage of the population	All medically indigent persons.	All persons not medically indigent.
Benefit structure	All services eligible as medical expense deductions under the income tax law may be covered. Insurance providing basic coverage of medical care and catastrophic protection of additional costs. Types of services determined by State. No cost sharing.	Coverage of 90 percent of family health care costs after the 1st $5,000 of expenses ($1,000 for the aged). Expenses paid by private insurance or public programs can be counted toward this deductible amount.
Administration	Private insurance companies would issue insurance policies and administer claims. DHEW would establish plan if State does not.	Administered by DHEW, using same procedures and requirements as Medicare, if possible.
Relationship to other Government programs	Would replace Medicaid program.	No specific reference. DHEW to report on laws that need to be changed.
Financing	Federal and State government general revenues. Federal pays 85 percent of cost of basic coverage. State pays remaining costs and cost of catastrophic protection.	Special tax on wages, self-employment income, and other income of individuals. Tax rate: 0.4 percent. Earnings subject to tax: Sum of an individual's wages, self-employment income, and other earned or unearned income over $2,000, up to a maximum of $7,800. Employment subject to tax: Same as social security.
Standards for providers of services	No provisions.	Same as Medicare, as much as feasible.
Reimbursement of providers of services	No provisions.	Same as Medicare, as much as feasible.
Delivery and resources	No provisions.	No provisions.

Catastrophic protection--LONG-RIBICOFF BILL

Subject	Provisions	
General concept and approach	Includes a (1) catastrophic illness plan for the general population and (2) Federal medical assistance plan for the poor and medically indigent. Both plans administered through the Medicare program. Also includes provisions designed to encourage improvement of private health insurance and establishment of insurance pools.	
Coverage of the population	Catastrophic plan: Persons of all ages insured, or receiving benefits, under social security.	Medical assistance plan: Families with income below specified amounts, varying by family size, regardless of age or employment status. Also families above specified limits under a "spend-down" provision which takes account of both family income and medical expenses. Present Medicaid eligibles automatically covered.
Benefit structure	Same types of benefits as Medicare, but payable only when expenses reach specified catastrophic proportions: Institutional services: Hospital inpatient: Coverage begins after first 60 days in hospital, unlimited additional days covered; $18 per day copayment. Skilled nursing facility: 100 days, available only to persons who received catastrophic hospital benefits; $9 per day copayment. Personal services:1/ Physicians services. Laboratory and X-ray. Home health services. Other services:1/ Medical supplies and appliances. Ambulance services. Total coinsurance limited to $1,000 annually per person.	No limits on amount of services and no cost sharing, except as indicated: Institutional services: Hospital inpatient: 60 days. Skilled nursing facility. Intermediate care facility. Personal services: Physicians services: $3 copayment for 1st 10 visits per family. Laboratory and X-ray. Home health service. Other services and supplies: Medical supplies and appliances. Ambulance services. Program would also pay full cost of benefits under catastrophic plan for medical assistance recipients not covered by the catastrophic plan, and necessary cost sharing for those who are covered. Would pay SMI premium for its aged eligibles.
Administration	Administered through the Medicare program, under which private carriers handle claims and pay providers of service.	
Relationship to other Government programs	Medicare: Continues to operate. Medicaid: Would pay last. Other programs: Mostly not affected.	Medicare: Continues to operate. Medicaid: Program abolished. Other programs: Mostly not affected.
Financing	As under Medicare, special tax on the wages and self-employment income subject to the social security tax. Tax rate: Initially, 0.3 percent, rising ultimately to 0.4 percent.	Financed by State and Federal general revenues. State share: Amount equal to present State share of Medicaid payment for types of service under new program, with additions or subtractions depending on liberality of present Medicaid program. Federal share: Balance of cost.
Standards for providers of services	Same as Medicare. Also, intermediate care facilities must be licensed by State and meet additional requirements.	
Reimbursement of providers of services	Same as Medicare (including the reimbursement provision of P.L. 92-603). For medical assistance program, physicians and other providers must accept plan's payment as payment in full.	
Delivery and resources	Incorporates the provisions of P.L. 92-603, including HMO provisions, and Professional Standards Review Organization (PSRO).	
Encouragement of improved insurance	Private carriers could voluntarily submit health insurance policies for certification by DHEW. Emblem of certification could be used in advertising and only "approved" carriers offering these policies could act as Medicare intermediaries. Certified policy must (1) include specified benefits (60 hospital days and $2,000 medical coverage) with limitations on cost sharing, (2) could not exclude preexisting conditions, and (3) if an employment group policy, continue coverage for terminated employees. Also, bill suspends certain antitrust laws, thus permitting insurance "pool" arrangements to offer certified insurance.	

1/ Payable after family has incurred $2,000 in medical expenses in year; 20 percent coinsurance.

ULLMAN BILL

The "National Health Care Services Reorganization and Financing Act" was introduced by Representative Al Ullman of Oregon as H.R. 1. It is supported by the American Hospital Association.

General Concept and Approach

The proposal would establish a three-part national health insurance program including (1) a plan requiring employers to provide specified private health insurance for their employees and their families, (2) a plan for individuals, and (3) a federally financed plan providing health insurance for aged, low-income, and medically indigent persons administered through Federal contracts with insurance carriers. The benefits of all plans would be the same.

The State governments would have major responsibility for administering the health insurance program and regulating providers of service and insurance carriers, in accordance with Federal rules. The State would also incorporate and regulate a system of health care corporations which would provide (through their own facilities or affiliated providers) comprehensive health care services to an enrolled population in designated geographical areas.

REQUIRED COVERAGE OF EMPLOYERS

The plan requiring employers to provide specified health insurance coverage for their employees would provide a broad range of services, generally subject to cost sharing by the patient. Additional catastrophic benefits would become payable when expenses exceed a specified amount. Coverage would be purchased from private insurance carriers, with the premium cost shared by employers and employees. Federal subsidies and tax deductions would be available under certain circumstances.

Coverage

The coverage requirement would apply to all employers subject to the social security tax including nonprofit organizations and other employers who have elected social security on a voluntary basis. It would not apply to Federal, State, and local governments as employers, nor to employees enrolled under federally contracted insurance (described below). Where two or more members of the family are employed (or an individual has more than one employer) coverage would be provided by the employer paying the highest wages.

The participation of employees would be voluntary. Employed persons eligible for an employee-employer plan are not eligible under the federally financed plan (for the aged, low income, and medically indigent) even though they meet the requirements of the Federal plan.

Coverage under the employers plan would be continued for 14 days for employees whose job is involuntarily terminated, but would cease when the employee became eligible for unemployment insurance. Coverage for workers receiving unemployment insurance would be provided through the Federal-State unemployment insurance system. Also, without regard to the cause of termination of employment, coverage would be available at the option of the employee for a period of 30 days, with the employee paying the entire premium.

Self-Employed Persons and Others

Coverage under the proposal would be made available on a voluntary basis at reasonable group rates to self-employed persons and other individuals (not eligible for federally contracted coverage). The arrangements for this coverage would be made by the States in accordance with Federal regulations.

Financing

The employer is required to pay at least 75 percent of the premium cost, and the employee the balance. Employers would receive subsidy payments from the Federal Government if their share of the premiums exceeds 4 percent of the average wages paid to employees. The subsidy would be equal to the amount of the excess, for a maximum of 10 employees. The coverage for persons receiving unemployment insurance would be financed by the Federal Government.

If an employed person was also eligible for the federally financed plan and his share of the premium contribution was larger than under the Federal plan, he would receive a subsidy from the Federal Government equal to the difference.

The premium for coverage for self-employed and other persons would be paid by the policy holder.

10-Percent Subsidy

Covered employees, self-employed, and other persons would receive a Federal subsidy if the family is (1) registered with a health care corporation, (2) enrolled in another organization providing comprehensive services to a defined population group through open enrollment, approved by the Department of Health, Education, and Welfare. The amount of the subsidy would be 10 percent of the group premium for covered benefits.

Income Tax Deduction

Under present law, persons who itemize their deductions on their individual income tax return may deduct one-half of their premium for private health insurance, up to a maximum of $150, as a medical expense deduction. Under the bill, persons who itemize could take their entire premium contribution for an approved plan as a deduction.

Benefit Structure

The required benefits of the program would be phased in in two stages with the initial benefits effective 6 months after enactment of the bill and the regular ones (referred to as comprehensive health care benefits) 5 years after enactment. (See pages 37-39.)

The timing of covered benefits are shown in table 1 and the benefit provision in table 2. The comprehensive health care benefits include catastrophic expense benefits, but the latter are shown in a separate column in table 2 because (as explained later) they would also be applicable to the initial benefits. Approved plans may include additional benefits (or eliminate or reduce the cost sharing) but these are not subject to the requirement or subsidies of the program.

Most benefits are subject to cost-sharing provisions requiring the patient to pay a flat dollar copayment or a percentage of the charges. The amount of the flat copayments would be increased, if the Consumer Price Index for a year rises by 3 percent or more over the previous year, at the same rate as the rise in the price index.

The nature of the health examination benefit, which is not specified in the bill, would be established by regulation. The bill states that consideration be given to providing the following:

Age 5-18.....	One examination every 5 years
Age 19-64.....	One examination every 2 years
Age 65 and over.....	One examination each year

The regulations would also establish the services and diagnostic tests included in the health examination and these could be varied for different age, sex, and other patient groups.

The provisions for physicians services are defined to include services of allied health personnel under the supervision of a physician. Services of chiropractors are covered on the same basis as under the Medicare program.

Mental Illness, Alcoholism, and Drug Abuse

Special provisions would apply to care for mental illness, alcoholism, and drug abuse and dependence. Inpatient hospital care for these conditions is covered only if the condition is in an acute phase. Days of care are limited to 45 days (instead of the usual 90 days) but the special 45-day limitation would not apply to a patient enrolled in a health care corporation.

Outpatient care for these conditions is covered, subject to the usual 10-visit limit and copayment of $2 per day. (The copayment may be waived, by regulation, for treatment of drug abuse or dependency.) Day care and similar part-time services are specifically covered, subject to a limitation of 3 days of care substituted for each day of allowable hospital care. The bill states that the regulations governing the mental illness services should be designed to encourage the use of outpatient programs.

As under the present Medicare program, services in a skilled nursing facility would be available after a hospital stay of 3 days or more. The covered benefits also include nursing-home care (available without a previous hospital stay) which would provide a less intensive level of care (referred to as health-related custodial care) to patients with an incurable disease who are bedridden, require certain nursing procedures or meet other conditions.

Catastrophic Expense Benefits

The catastrophic expense benefits, which become effective after a specified expenditure by the patient for noncovered expenses, would liberalize the conditions applicable to the regular benefits. They would eliminate the cost sharing for all benefits and remove the limits on the number of (1) inpatient hospital days, except for care of mental illness, alcoholism, and drug abuse, (2) physicians' home, office, and outpatient visits, and (3) outpatient services for mental illness, alcoholism, and drug abuse.

The catastrophic benefits would be payable when specified noncovered medical expenses reach a certain total (the "expense limit"), which varies according to family income and age. The expenses that would be counted in determining this expense limit are (1) premiums paid for an approved health insurance policy, (2) expenses for cost sharing, and (3) expenses resulting from the limitation on the number of inpatient hospital days (except for mental illness, alcoholism, and drug abuse); skilled nursing facility days; physicians' home, office, and outpatient visits; and outpatient mental illness, alcoholism, and drug abuse services. Expenses incurred in the last 3 months of a year could be included in the next year's expense limit.

The family income classes (which are based on family size and income) used in determining eligibility for catastrophic benefits are the same as used in determining eligibility for federally subsidized health insurance (see page 22). A separate set of expense limits is applicable to families under age 65, and those age 65 and over. For the lowest income class, the expense limit is, in effect, zero and the catastrophic benefit is always in effect. The expense limit for the highest income class is not specified, but is calculated as 10 percent of income. The expense limits are as follows:

Income class	Expense limit	
	Under age 65	Age 65 and over
1	0	0
2	$250	$125
3	500	250
4	750	375
5	10 percent of income	

Initial Benefits

The initial benefit provisions would provide the same benefits as the present Medicare program. In addition, catastrophic expense benefits (similar to those described above) would be provided; they would remove the cost sharing, and the limitation on hospital days, applicable to Medicare benefits (tables 1 and 2).

Administration

The employer would purchase private health insurance for his employees from an insurance carrier qualified under the program. Also a health insurance plan must meet certain requirements to be eligible for the 10-percent subsidy available to enrollees of a health care corporation and similar approved organizations. The qualifications and requirements for carriers are described later.

COVERAGE OF AGED, LOW INCOME, AND MEDICALLY INDIGENT

The Federal Government would provide health insurance coverage for the aged, low-income, and medically indigent groups through contracts with insurance carriers. The permanent benefits would be the same as under the required employer plans, although the interim benefits would be phased in differently. The benefits would be financed from the present Medicare payroll tax, Federal general revenues, and premium contributions from the medically indigent.

Coverage

Aged persons (65 and over) would be eligible for Federal coverage without regard to income, and eligibility for low-income and medically indigent individuals and families would be based on family income and size shown as follows:

Income class	Family size and income			
	Single individual	Family of 2	Family of 3	Family of 4 or more
1...	$0-$2,000	$0-$3,000	$0-$4,500	$0-$6,000
2...	2,001- 3,000	3,001- 4,500	4,501- 6,000	6,001- 7,500
3...	3,001- 4,500	4,501- 6,000	6,001- 7,500	7,501- 9,000
4...	4,501- 6,000	6,001- 7,500	7,501- 9,000	9,001-10,500

Note: Families are defined as parents and dependent children under age 19.

The families in class 1 are defined as the low-income group and those in classes 2, 3, and 4 as the medically indigent. The determination of income would be based on the adjusted gross income shown on the income tax return, but specified kinds of income could be included or excluded, as determined by regulation, if they are considered as readily available for living expenses (or not so). Also income could be determined on a more current basis if necessary to prevent hardship.

The dollar amounts shown in the table would be increased, if the Consumer Price Index in a year rises by 3 percent or more, at the same rate as the index.

Benefit Structure

The federally contracted insurance would provide the same permanent benefits subject to the same conditions as are applicable to employed persons, and these would also begin 5 years after enactment of the bill (tables 1 and 2). The catastrophic benefits would also be payable according to the income class and age; the table of expense limits is repeated as follows:

Income class	Expense limit	
	Under age 65	Age 65 and over
1	0	0
2	$250	$125
3	500	250
4	750	375

Initial Benefits

The initial benefits for the three groups under federally contracted insurance would be phased in, as described below (table 1).

Aged.--Under the present Medicare law, all qualified aged persons are automatically covered for hospital insurance benefits (Part A), but enrollment for supplementary medical insurance (Part B) is voluntary and requires payment of a premium. Under the proposal, beginning 6 months after enactment, all of the aged would automatically be covered under medical insurance and the premium would be eliminated. At this time, the aged who qualify as low-income persons would also receive catastrophic expense coverage (which would eliminate the cost sharing and hospital limitations of the Medicare benefits). Three years after enactment, all of the aged would be eligible for catastrophic expense coverage.

Low income.--Six months after enactment, low-income families would become entitled to the same benefits as provided under the Medicare program, with no cost sharing required (but with the limits on the number of hospital days retained).

Medically indigent.--The medically indigent families would first become eligible for benefits 3 years after enactment, at which time they would receive Medicare benefits supplemented by catastrophic expense coverage.

Financing

The aged and low-income groups would not pay any premium for the Federal coverage. The medically indigent would pay an annual premium, according to their income class, as shown below. The amount of this premium contribution would be raised, if the Consumer Price Index in a year rises by 3 percent or more, at the same rate as the rise in the index.

	Individual	Family
Class 2	$50	$125
Class 3	100	250
Class 4	150	375

Other Sources of Funds

The payroll tax levied to finance the benefits of the present Medicare program would continue. All additional costs of the program would be appropriated from Federal general revenues.

The amount of general revenue needed to finance the program (including the cost of the federally contracted insurance, the 10-percent subsidy described previously, and the administrative costs of the program) and to establish a 5-percent reserve would be estimated by the Department of Health, Education, and Welfare. The estimate would be based on past experience and expected changes in the cost of services, the number of low-income and medically indigent persons, the utilization of health services, and the amount of contributions from the medically indigent.

The Medicare trust funds would be retained and would receive the proceeds from the Medicare tax and the general revenues applicable to the aged (except the additional cost for their catastrophic coverage). All other funds would be paid directly from general revenues.

Administration

The Federal Government would contract with insurance carriers for health insurance for persons eligible for Federal coverage. The carrier must be one qualified to issue subsidized insurance plans (as explained later) and could include carriers underwriting a health care corporation or a corporation, operating on a capitation basis, acting as its own carrier.

The negotiation of the contract would not necessarily be subject to competitive bidding and other standard Federal contract requirements, but information about the proposed contract would be made available to all carriers. Contracts with more than one carrier could be made to provide coverage in an area. Also, a contract could require a carrier to subcontract the insurance with other carriers, or a contract could be made with a combination of carriers (which have established a joint arrangement or organization for this purpose). The Federal Government could use the State as its agent in negotiating contracts.

Enrollment

The conditions for enrollment under the plan would be prescribed by Federal regulations. Open enrollment periods would be held (which would be concurrent for the various carriers and corporations offering federally contracted plans in an area).

Federal regulation would determine the method of payment of premiums by the medically indigent (which could be direct to the carrier, the State commission, or other methods). As prescribed by regulations, a grace

period of not more than 90 days would apply in event of nonpayment of premiums before the insurance could be terminated.

Relationship to Other Government Programs

The Medicare program for the aged would be replaced by the new program. Federal financing for the Medicaid program would eventually be limited to services not covered under the new program (but would remain in effect for various population groups and services during the phasing-in period). Federal regulations would establish a new minimum scope of services required under a State Medicaid program, in lieu of the services required under present law, and these would be designed to supplement the benefits under the proposal.

Federal financial assistance under the Maternal and Child Health Program would be limited to noncovered services for persons covered by federally contracted insurance.

ADMINISTRATION AND REGULATION OF THE PROGRAM

The proposal would place major responsibility for administration of the program, in accordance with Federal regulations, on the State. The major provisions relating to State administration of the program would be presented in the State health care plan which would include the regulations for providers of service and insurance carriers and the provisions for establishment and supervision of a system of health care corporations.

Federal Administration

The primary Federal responsibility for the program would be lodged in a newly created department of health and all health programs of the Department of Health, Education, and Welfare (and certain health programs of other departments) would be transferred to this new department. The department would be responsible for the establishment of Federal regulations, review of State compliance with the program, evaluation of the program, and annual reports to the President.

A national health services advisory council of 20 members, appointed for 4-year terms, would include representatives of providers of services and consumers (with the latter to constitute at least one-half its members). The council would advise the department on policy, including prior review and comment on proposed regulations. It would make an annual report to the department and the Congress. The department would be required to report to Congress its views on recommendations about administration (if not adopted), and on the council's legislative recommendations.

State Administration

State responsibility for the programs would be placed in an independent State health commission, composed of three or five members appointed by the Governor for 6-year terms (with a maximum of two or three members, respectively, from the same political party). Representatives of the health care professions could not constitute a majority of the members. Members would be full-time employees, could not hold a financial interest in a health care provider, and could be removed only for cause.

The commission would be advised by a State advisory council which would include representatives of providers (including health care corporations, other providers, professional organizations and societies, and medical schools) and of consumers, with the latter constituting at least one-half the membership.

State Health Care Plan

The State health care plan would be developed by the commission, in consultation with the advisory council, after giving the general public an opportunity to present its views. The plan would need to be approved by the Federal Government. Disapproval would be subject to a hearing and review by Federal courts.

If the State failed to obtain an approved plan within 3 years after enactment of the bill, the Federal Government could intervene and administer the program in the State. It could also intervene if the approved plan is not properly administered, or is later modified, so that it is no longer in compliance with law.

Federal grants would be available to cover the entire cost of developing a State plan, and the following percentage of the cost of administering the plan:

90 percent for the year before benefits begin
85 percent for the first 2 years of program
75 percent thereafter

Reimbursement of Providers of Services

Payments to providers of service would be based on approved charges of providers, in accordance with Federal and State regulations. The Federal standards indicating the financial requirements of institutions and health care corporations, to be met by third parties, are as follows:

(1) direct and indirect patient expenses, including free services to indigents;

(2) expenses of approved education and research programs;

(3) working capital and interest;

(4) "price level depreciation" for assets (which takes account of rising prices, as opposed to historical cost depreciation);

(5) payments related to construction, modernization, and expansion of specified projects in years when expenditures for those projects exceed depreciation charges, provided that the total payments for the projects over their lifetime do not exceed the price level depreciation charges payable over their lifetime;

(6) a return on total assets based on rates of return for investments of comparable risks, to be included as a factor for developing prospective rates for proprietary institutions and for evaluating the financial requirements of nonprofit institutions.

For noninstitutional providers (professional and related), payments would be based on reasonable fees, salaries, or other compensation.

Approval of Charges

The State commission would approve charges for institutional providers based on a review of their budgets (prepared according to a uniform system of accounting) and a schedule of charges proposed by the provider. Charges for kinds of physicians' services provided in an institution which are generally available to all inpatients (such as radiologists and pathologists services) would be included in the institutions' budget and not as separate physicians' charges. Payment for unneeded services or for unapproved capital expenditures would not be allowed. Providers dissatisfied with the commission's decisions would be entitled to a hearing. The approved charge schedule would be applicable to all qualified private plans and to federally contracted coverage. The commission would also review charges of all licensed noninstitutional providers.

In general, the insurance carrier would pay the covered charges, and the patient would pay the cost sharing, to the provider. However, where a carrier insures a corporation which is not on a capitation basis, the carrier would pay the covered charge to the corporation and collect the cost sharing from the patient.

Standards for Participation of Providers

Standards for participation of providers would be established by Federal and State regulations. The minimum Federal standards for various types of providers indicated in the bill are as follows:

(1) hospitals, skilled nursing facilities, and home health agencies must meet the standards of the Medicare program (as under Medicare, approval by State agencies or accreditation by certain national organizations would be accepted);

(2) skilled nursing facilities would need to be physically a part of, or in the immediate proximity to, a hospital and must be under the supervision of the professional staff of a hospital or have an organized medical staff;

(3) home health services must be furnished by a health care corporation (directly or through an affiliated provider);

(4) the use and qualification of paramedical personnel acting as assistants to physicians and dentists must meet Federal standards (the use of personnel according to these Federal standards can not be further restricted by State law).

Scope and Quality of Service

Providers of service would be required to comply with Federal and State standards concerning (1) the quality and, where applicable, the scope and comprehensiveness of services, (2) the control of the utilization of services, and (3) appraisal of the effectiveness of their services. For these purposes, the provider must establish systems of peer review, medical audit, and other procedures similar to the requirements for health care corporations, described later. The commission would review and approve peer review systems, and review the performance of providers in these matters.

Health Planning and Facilities

The commission would take responsibility for implementation and coordination of health facility planning (1) developed under the State health care plan; (2) State, regional, and local plans under the comprehensive health planning act; and (3) plans under other Federal or State programs.

Construction, modernization, or expansion of health care facilities or services by hospitals, skilled nursing facilities, nursing homes, or other organizations would not be permitted unless approved in advance by the commission.

On request of the Department of Health, Education, and Welfare, the State commission would review and recommend on applications of providers and other organizations for grants and contracts under various Federal laws, and act as its agent in enforcing compliance with Federal requirements.

Enforcement Powers

The commission could take corrective action against a provider of service which failed to fulfill its obligations, including suspension of payments for covered benefits (subject to hearing and court review).

Participating providers are prohibited, under penalty of Federal law, from soliciting or taking kickbacks or bribes in connection with covered services, or making rebates of fees or charges for referral of patients.

Regulation of Insurers

The commission would regulate health insurance carriers and approve carriers and insurance plans for participation in the program. Various kinds of organizations could qualify as an approved carrier, including organizations which pay for (or provide) health care on a group basis by contract, agreement, membership, or subscription arrangements; or a health care corporation acting as its own carrier.

Regulation of Premium Rates

The commission would be responsible for regulating the premium rates of carriers issuing qualified private plans under the proposal, but (except for health care corporations acting as its own carrier) regulation could be delegated to the State insurance department or other agency. Federally contracted plans would not be subject to State regulations.

Qualifications for Subsidized Insurance

An insurance plan, to be eligible for the 10-percent Federal subsidy (available for families enrolled in a health care corporation or similar approved organization), must meet the following requirements:

(1) provide coverage and benefits without regard to health status (such as preexisting conditions), economic status, race, sex, occupation, age, or any conditions indicated in regulations; classification of risks for the purpose of setting different premium rates would be permitted only according to actuarial principles;

(2) provide for coordination of duplicate coverage, as prescribed by Federal regulations;

(3) report to the Federal Government on financial matters, utilization of services, peer review of quality of services and other matter, as required by regulation, and make its records available for inspection;

(4) meet other requirements of the State plan.

Federal insurance contracts would be made only with carriers who are qualified to issue subsidized plans and meet any additional Federal requirements that may be established.

The State would be responsible for providing, by regulation, arrangements to assure all residents of the State an opportunity to obtain coverage. Carriers for federally contracted insurance must participate in a State coverage pool, if requested by the State.

Prospective Regulations

Amendments to the law or new regulations, enacted or issued in a year, which would affect the obligations or rights of carriers, would not go into effect until the following contract year (except where mutually agreed).

Evaluation of the Program

A national uniform statistical program would be established by the Federal Government. Each State commission would function as a center for the collection of health statistics and information, and providers and carriers would be required to report statistical information. (Safeguards would be provided to prevent disclosure of identifying information.)

As prescribed by Federal regulations, the commission would evaluate the health-related and economic effectiveness of its activities, and of health care corporations and other providers. The evaluation would include a comparison of utilization of services for health care corporations and for other providers. The evaluation and other reports required by regulation would be filed with the new department of health. At the Federal level, the department would evaluate the effectiveness of the program.

Disputes and Claims

The commission would settle disputes between individuals, providers, health care corporations, and insurance carriers by providing hearings before it in the following situations:

(1) claims by individuals against a provider or carrier (or vice versa) where the disputed amount is $100 or more;

(2) allegation by an individual of the failure of providers to meet their obligations, where the failure is part of a pattern of similar conduct;

(3) claims by a provider against a carrier for payment of charges for services (or for capitation charges);

(4) disputes between health care corporations and affiliated or nonaffiliated providers.

HEALTH CARE CORPORATIONS

A health care corporation is defined as a nonprofit or governmental organization which is organized to (1) furnish comprehensive and coordinated health services through its own facilities or affiliated providers, (2) conduct related educational, research, and other activities, and (3) provide adequate representation of its enrollees and affiliated providers on its governing board. The provisions and regulations for providers of service described above (and for insurance carriers where the corporation acts as its own carrier) would apply generally to corporations. Additional and specialized provisions applicable to corporations are described here.

Establishment of Corporations

The State commission would have responsibility for establishing a system of health care corporations in its State. It would assist organizations wishing to establish corporations by providing information, advice, and assistance in applying for Federal grants.

The commission would approve corporations to operate in specified geographical service areas. Service areas need not coincide with existing political boundaries and could extend across State lines, and the commission would assist in arranging with other States to establish joint areas. Organizations submitting applications for approval as a corporation would designate their preferred service area.

Applications for corporations would be evaluated according to the following criteria:

(1) the applicant's organization, management, resources, financial responsibility, and conformance with other requirements;

(2) the need for the proposed services in the area; and

(3) the need for an additional corporation.

If more than one application is pending, the applications would be considered simultaneously. The commission would consult with representatives of the public, providers, and government agencies before approving

corporations and their service areas. The commission (or another State agency) would incorporate approved organizations under State law. The initial approvals of corporations must be completed 4 years after enactment of the bill.

Enrollment

Periodic open enrollment periods would be held, with the conditions for enrollment determined by Federal and State regulation. At the start of the enrollment period, the corporation must provide full information to the public about its operations and services. It must enroll all persons living in its service area who apply, and could not discriminate (in enrollment or in providing services) on the grounds of race, creed, color, national origin, age, sex, occupation, economic status, or conditions of health. The corporation must make reasonable efforts to enroll persons assigned by the commission. An applicant who is not accepted could obtain a hearing before the commission.

Where the capacity of a corporation is limited, enrollment may be limited (with the approval of the commission) on a first-applied basis, but only if other approved corporations are available in the area. With the commission's approval, the corporation could enroll persons living outside its area and others it is not required to enroll. The corporation would assist eligible enrollees to obtain federally contracted coverage.

Medical Services

The bill states that the services of the corporation would, to the extent possible, (1) emphasize health maintenance and health education, (2) assure continuity of care and appropriate referral, (3) provide maximum care on an outpatient basis, (4) make services readily available, and (5) furnish outpatient care in places accessible throughout the area.

The corporation would be required to furnish to its enrollees all the hospital and medical services covered under the insurance provisions of the proposal. Emergency and ambulance services must be made available at all times. The corporation must schedule a periodic health examination for each enrollee.

The corporation would also be required to provide health education services designed to encourage healthful living and proper use of services, especially for low-income and medically indigent enrollees, with special assistance given to persons with language or educational handicaps.

A continuing personal health record (including medical histories and other information) would be maintained for each enrollee and be made available to the corporation's staff and affiliated providers (and, for emergency care, to unaffiliated providers). These records would be transferred when a member transfers to another corporation. The health records (which could be used for statistical purposes) could not be disclosed without the enrollee's permission, except when necessary for the administration of the program.

The corporation would be required to give emergency services to persons not enrolled with it and, if resources are available, could provide other services to nonenrollees.

Methods of Providing Services

The corporation could provide services directly through its own facilities and personnel, or through affiliated providers under contract with it. Affiliated providers could be institutions (hospitals, nursing facilities, or home health agencies) or practitioners (physicians, dentists, podiatrists, or optometrists). An affiliated provider could be a solo practitioner, partnership, clinic, or group practice plan and could be affiliated with more than one corporation (with one affiliation designated as the primary one).

Prescription drugs, medical appliances and equipment, and ambulance services could be furnished by nonaffiliated providers under approved arrangements. Specialized services could be also provided by arrangement with an unaffiliated provider.

Practitioners

Within its needs, the corporation must permit all practitioners to furnish services for it as staff members or affiliated providers. Also, consistent with its type of organization, the corporation must permit practitioners to choose their form of practice. The corporation would determine annually the scope of services that practitioners would be permitted to perform. It could not discriminate, in selecting practitioners or determining their services, on grounds unrelated to qualifications (but could prefer those located in the service area).

The bill states that medical judgments could be made only by physicians, that medical policies must be established with the advice of physicians, and that the participation of physicians in policy formulation and administration of the corporation should be encouraged. Physicians could not be disqualified, by State law or regulations, from serving on the governing board of a corporation.

Outpatient Centers

Through affiliated providers or other methods, outpatient centers would be established to furnish primary medical care and (to the extent possible) health maintenance services, home health care, medical social services, and well-baby and mental health care. The centers would make arrangements with other corporation facilities for additional diagnostic services and referral and transfer of patients.

Quality of Services

The corporation would be required to comply (for its own and affiliated services) with the general standards, described previously, concerning the quality and comprehensiveness of service, controls on utilization, and appraisal of the effectiveness of service. It must establish for this purpose, a system of peer review of medical services by a group of physicians (from the corporation and affiliated providers) and require similar review by a staff committee of affiliated hospitals and skilled nursing facilities. The State commission would review and approve the peer review system and evaluate the performance of the corporation.

The qualification of personnel must at least meet standards of professional organizations. The corporation must establish a program of continuing education for physicians, dentists, and nurses and, at its option, other professional personnel.

Charges and Reimbursement

Charges of corporations would be approved by the commission, based on the financial requirements needed to fulfill its responsibilities, in accordance with the general principles of reimbursement described above. Corporations would be responsible for justifying the budget and charges of affiliated providers.

Initially, the corporation could charge its enrollees either an annual capitation charge or separate charges for each service, but capitation must be made available to persons who wish to enroll on this basis, beginning 5 years after incorporation. The basic capitation amount would be the same for all enrollees, varied only by family size and composition, but a different rate could apply to federally contracted insurance.

The corporation would be responsible for payment for services given to its enrollees by out-of-area corporations, and emergency services provided by a nonaffiliated provider.

The methods of payment or compensation by the corporation to its staff and affiliated providers would be as mutually agreed. Arrangements between corporations and practitioners (which could be on a capitation, fee-for-service, or other basis) could not be restricted by State law or regulation.

Study of Capital Needs

The national health services advisory council, mentioned above, would make a special study of the capital needs of health care corporations and related organizations to examine methods of replacing traditional sources of capital financing with a national funding program. It would give consideration to establishing a national trust fund financed from health insurance premiums, a tax on these premiums, appropriated funds, or other public or private sources.

Other Activities

Manpower.--Corporations would coordinate personnel needs for itself and affiliated providers, conduct in-service training, and encourage the use of physicians' assistants and other paramedical personnel.

Records and reports.--Corporations would be responsible for keeping records and reports (for itself and affiliated providers) on financial matters, utilization of services and results of peer review. These records would be available for inspection by the commission for verification.

Evaluation and research.--Corporations would evaluate their own performance and conduct research on the delivery, quality, and cost of health services which would be made available to State and Federal Governments.

Grievances and Representation

The corporation would be required to establish procedures for handling grievances of enrollees or applicants for enrollment (and maintain records of the grievances for inspection by the State commission) and for settling disputes with affiliated and other providers.

The corporation would establish an advisory committee to represent its enrollees (and additional subcommittees or separate committees to represent groups of members with special interests) and provide other methods to permit its enrollees to express their views on its policies and operations.

Enforcement Powers

If the State commission determines that a corporation is not complying with laws or regulations, it could direct the corporation to correct the situation, take other action such as placing the corporation in receivership, or amend or repeal its approval. These orders or actions would be subject to hearing and court review. Also, other interested parties, such as other corporations and providers, could initiate an action to amend or revoke the approval of a corporation.

Federal Grants

The bill states the policy of the Federal Government to assist in the development of health care corporations, especially in poverty and rural areas, and appropriates, to the extent needed, funds for financial assistance to corporations as follows:

(1) grants for planning and development of corporations;

(2) grants for new or expanded outpatient care centers (also available to nonproprietory providers affiliated with corporations);

(3) grants for medical equipment, data processing systems, and central-service equipment needed for initial operations; and

(4) contracts to pay the operating deficit of new or expanded corporations for a reasonable period.

In providing financial assistance, the Federal Government would consider the resources availability in various geographical areas and attempt to provide an equitable distribution of assistance. A maximum of 15 percent of the funds could be granted in any one State. For the first 5 years of the program, priority would be given to corporations operating on, converting to, or planning to convert to, a capitation basis and thereafter only to such corporations. Applications for financial assistance must be approved by the State commission.

In addition, the bill directs all Federal agencies providing financial assistance in the field of health care (such as construction of facilities) to use their funds to further the new program, and to give priority to health care corporations, especially those in poverty areas.

TABLE 1.--ULLMAN BILL: Effective date of benefits

Group	Type of benefits and effective date		
	6 months 1/	3 years 2/	5 years 3/
General population: Employees.....	Medicare benefits Catastrophic expense		Comprehensive health care
Self-employed and others.....	Medicare benefits Catastrophic expense		Comprehensive health care
Persons receiving unemployment insurance.....	Medicare benefits Catastrophic expense		Comprehensive health care
Federally contracted insurance: Aged.....	Medicare benefits: Automatic coverage under Part B Catastrophic expense for low-income group	Catastrophic expense for all	Comprehensive health care
Low-income.....	Medicare benefits, with no cost sharing		Comprehensive health care
Medically indigent	None	Medicare benefits Catastrophic expense	Comprehensive health care

1/ Effective at the beginning of the first calendar or fiscal year which occurs 6 months after enactment.
2/ Effective at the beginning of the first fiscal year which occurs 3 years after enactment.
3/ Effective at the beginning of the first fiscal year which occurs 5 years after enactment.

TABLE 2.--ULLMAN BILL: Initial, comprehensive health care, and catastrophic expense benefits

Type of service	Initial (Medicare) benefits		Comprehensive health care benefits			Catastrophic expense benefit
	Benefit (in benefit period)	Cost sharing	Benefit (in benefit period)	Cost sharing	Other information	
Institutional services						
Hospital inpatient	90 days (plus 60-day lifetime reserve).	Deductible and coinsurance after 60th day.1/	90 days	$5 per day	Special provision for mental illness, alcoholism, and drug abuse.	No cost sharing, no limit on days.
Skilled nursing facility	100 days 2/	Coinsurance after 20th day.1/	30 days	$2.50 per day	Available after hospital stay of 3 days or more.	No cost sharing.
Nursing home	No benefit		90 days	$2.50 per day		No cost sharing.
Personal services						
Physicians' services: In home, office, and outpatient center	No limit	$60 deductible, 20 percent coinsurance.3/	10 visits per year.4/	$2 per visit.4/	Special provisions for mental illness, alcoholism, and drug abuse.	No cost sharing, no limit on visits.
In hospital and other institution	No limit	$60 deductible, 20 percent coinsurance.3/	No limit	$2 per visit.4/	Copayment applies only to attending physician.	No cost sharing.
Diagnostic services	No limit	$60 deductible, 20 percent coinsurance.3/	No limit	20 percent	No cost sharing for enrollees of health care corporations.	No cost sharing.
Health examinations	No benefit		By regulation	None		
Immunizations	No benefit		No limit	None		
Well-baby care	No benefit		(Per year)			
Under age 1			8 visits	None		
Age 1 to 2			4 visits	None		
Age 2 to 5			2 visits	None		

See footnotes at end of table.

TABLE 2.--ULLMAN BILL: Initial, comprehensive health care, and catastrophic expense benefits--Continued

Type of service	Initial (Medicare) benefits		Comprehensive health care benefits			Catastrophic expense benefits
	Benefit (in benefit period)	Cost sharing	Benefit (in benefit period)	Cost sharing	Other information	
Personal services--Continued						
Home health services	200 visits 2/	None	100 visits per year	$2 per visit		No cost sharing.
Dental services (for children):						
Examination and cleaning	No benefit		1 visit per year	None	For children up to age 7; once child is covered, benefits continue to age 12.	No cost sharing.
Other services	No benefit		Routine dental care, by regulation.	20 percent		No cost sharing.
Vision services (for children):						
Examination	No benefit		1 visit per year	None	For children up to age 12; includes services of physician or optometrist.	
Eyeglasses	No benefit		1 set per year	20 percent		
Other services and supplies						
Prescription drugs	No benefit		Drugs necessary for specified conditions requiring expensive drug therapy, or especially important to the public health; by regulation.	$1 per prescription.	List of drugs to be shown by generic names.	No cost sharing.
Prosthetic devices	By regulation	$60 deductible, 20 percent coinsurance. 3/	By regulation	20 percent	May include hearing aids.	No cost sharing.
Medical equipment	By regulation	$60 deductible, 20 percent coinsurance. 3/	By regulation	20 percent		No cost sharing.
Ambulance services	No limit	$60 deductible, 20 percent coinsurance. 3/	No limit	20 percent	Only when medically necessary.	No cost sharing.

1/ The Medicare hospital deductible for 1973 is $72. The hospital coinsurance rate after 60 days is one-quarter of the deductible ($18) and, for the lifetime reserve, one-half ($32). For skilled nursing facilities, the rate is one-eighth ($9). The amount of the deductible is raised each year if the per diem cost of inpatient hospital cost increases.

2/ Skilled nursing care and 100 home health visits are provided under Part A after a hospital stay of 3 days or more. Also, 100 home health visits are available under Part B with no coinsurance.

3/ The $60 deductible is a common deductible applicable to specified services.

4/ If a single combined change is made for services in and outside the hospital (e.g., for surgery or obstetrical care), the out-of-hospital visits would be exempt from the 10-visit limitation and coinsurance of 10 percent of charges would apply in lieu of the $2 copayment.

RAILSBACK BILL

The "National Health Insurance Partnership Act of 1971" was introduced by Representative Thomas F. Railsback of Illinois as H.R. 2618.

General Concept and Approach

The proposal would establish a two-part national health insurance plan that would cover almost all of the population under age 65. These include (1) a plan requiring employers to provide for employees and their families private health insurance with specified benefits and (2) a federally operated family health insurance plan for low-income families with children. The proposal includes provisions designed to encourage the formation and use of health maintenance organizations.

NATIONAL HEALTH INSURANCE STANDARDS ACT

The "National Health Insurance Standards Act" would require employers to make available to employees and their families a health care plan under private insurance providing specified benefits. Most benefits would be subject to cost sharing by the patient. The program would be administered by private insurance companies, under Federal supervision, and would be financed by employer-employee premium contributions.

Coverage of the Population

The Act would apply to all employers and employees except (1) employees of Federal, State, and local governments, (2) ministers and members of religious orders, and (3) aged persons under the Medicare program. All other employers must make coverage available to all full-time and part-time employees (who work at least 25 hours a week for 10 weeks, or a total of 350 hours in a 13-week period). The participation of the employee would be on a voluntary basis.

Coverage would be continued, at the option of the employee, for at least 90 days after employment terminated (if he was under the plan for at least 13 weeks) and could be continued further, but the employer would not be required to pay any premiums after the 90-day period.

Special group plans developed by insurance carriers would be available to small employers (those with less than 100 employees working 90 days or more during a 180-day period). Also, group plans would be developed for self-employed persons and other persons not under an employer plan. These special group plans would have to provide the same benefits and meet the same requirements as employer plans.

Employers with a collectively bargained health care plan in effect at the time the bill is enacted (and still in effect when the program began) would not have to establish a required plan until the contract expired.

Benefit Structure

The required employer plan would have to provide specified benefits and meet certain requirements. The plan could not exclude payment of benefits because of preexisting conditions for more than 6 months. (There could be no waiting period for maternity care.)

Hospital room and board is subject to a "2-day deductible" which refers to the reasonable cost for room and board for 2 days of care.

Most other benefits would be subject to an annual deductible of $100 per person, with a family maximum of three deductibles, plus 25 percent coinsurance (referred to below as "deductible and coinsurance"). This deductible is the total annual amount payable per person for all services subject to deductibles. After a person has received $5,000 of services in a year, all the cost sharing would be waived for him and his family for that year and the next 2 years.

There would be a lifetime maximum limit of $50,000 on total payments per person, with a $2,000 annual restoration. The covered benefits are shown as follows:

Institutional Services

Hospital inpatient care: 2-day deductible and 25 percent coinsurance for room and board per year. All other hospital services subject to deductible and coinsurance.

Hospital outpatient care: subject to deductible and coinsurance.

Personal Services

Physicians' services (nonpsychiatric): subject to deductible and coinsurance. Periodic examinations for children under age 5 (including immunizations and preventive care) with no cost sharing: six exams, birth to 6 months; six exams, age 7 months to 2 years; three exams, age 2 to 5 years. Annual eye examination for children up to age 12 subject to deductible and coinsurance.

Laboratory and X-ray: subject to deductible and coinsurance.

Outpatient physical therapy services: subject to deductible and coinsurance.

Other Services and Supplies

Medical supplies and appliances: subject to deductible and coinsurance (prosthetic devices excluded).

Ambulance services (only in emergencies): subject to deductible and coinsurance.

An employer plan could also make available benefits additional to those specified (or reduce or eliminate the cost sharing requirements). The employee would not be required to accept (or pay for) these additional benefits to be covered under the required plan. These additional benefits would not be subject to the requirements or conditions applicable to the required plan.

Administration

Employers would purchase basic health care plans from private insurance carriers who would collect the premiums and process the claims for benefits. They could also operate a plan on a self-insured or similar basis. Employees would have the option of enrolling with an approved health maintenance organization (these organizations are described later) and the employers would contract with these organizations for those employees who chose to enroll. Individuals and small employers could purchase coverage under special group plans.

The Department of Health, Education, and Welfare would be responsible for approving the employer plans and the special group plans. It would determine whether providers of services (including health maintenance organizations) meet standards and other requirements of the bill. It would also establish procedures for hearings in cases of denial of benefits by health maintenance organizations.

If the Department finds that an employer is not making a required plan available to his employees, the Federal Government could bring suit to compel the employer to do so. Employees may also bring suit.

Financing

Basic health care plans would be financed by premium contributions, with the employer paying at least 75 percent of the cost (for the first 2-1/2 years of the program, at least 65 percent). The provisions do not apply to the cost of any additional benefits included in the plan. The employer could, of course, pay the entire cost of the plan if he wishes to do so.

Employees who enroll in a health maintenance organization would pay no more than the regular premium for a required employer plan, but could

be required to pay an additional premium for any additional types of services provided (and for the actuarial value of the deductibles and coinsurance if these are reduced or eliminated by the organization).

Employers would receive subsidy payments from the Federal Government if their premium costs for employees covered under a required plan exceed 4 percent of the average wages paid to those employees. These payments would be equal to the amount of the excess for a maximum of 10 employees.

Employers would be able to take their unsubsidized premium contributions toward a required plan as a tax deduction.

FAMILY HEALTH INSURANCE PLAN

The "Family Health Insurance Plan" (FHIP) would establish a plan for low-income families with children not covered under a required employer plan. Benefits would generally be subject to cost sharing, which would vary with family income and size, but the lowest income group would pay nothing. The program would be administered by the Federal Government and would be financed by Federal general revenues, and by premium contributions (except for the lowest income group) graduated according to family income and size. The Medicaid program would be limited to the aged, blind, and disabled; persons age 65 and over would remain under Medicare.

Coverage of the Population

Low-income families with children could enroll in the family health insurance plan provided:

(1) their total annual family income does not exceed specified levels and total family resources do not exceed $1,500,

(2) the family member is not covered by Medicare or a required employer plan, and

(3) the family includes at least one dependent child under age 18 (or a student under age 22).

Families receiving payments under the proposed Family Assistance Plan (FAP) would automatically be covered.

Income Levels

Eligibility for coverage would depend on the family's annual income level as follows:

One-member family	
Family of 2	$2,500
Family of 3	3,400
Family of 4	4,200
Family of 5	5,000
Family of 6	5,800
Family of 7 or more	6,400
	7,000

Both earned and unearned income would be counted in determining family income, including payments under FAP, but food stamps and payments for foster children would not. In determining the $1,500 maximum on family resources, a family's home, household goods, and other personal effects would not be counted, nor would property essential to the family's self-support. Eligibility would be redetermined every 6 months. Coverage would end 9 months after notification that a person is no longer eligible (6 months if he becomes eligible for Medicare or is covered under a required employer plan).

Benefit Structure

The benefits provided under the family health insurance plan are shown in table 1. For the purpose of determining any deductibles and coinsurance amounts which may be applicable (as well as any premiums required, as discussed later) the eligible families are divided into five classes, depending on their income and size, according to the following tabulation:

Family size	Income class				
	1	2	3	4	5
1.....	0-$500	$501-$1,000	$1,001-$1,500	$1,501-$2,000	$2,001-$2,500
2.....	0-1,400	1,401-1,900	1,901- 2,400	2,401- 2,900	2,901- 3,400
3.....	0-2,200	2,201-2,700	2,701- 3,200	3,201- 3,700	3,701- 4,200
4.....	0-3,000	3,001-3,500	3,501- 4,000	4,001- 4,500	4,501- 5,000
5.....	0-3,800	3,801-4,300	4,301- 4,800	4,801- 5,300	5,301- 5,800
6.....	0-4,400	4,401-4,900	4,901- 5,400	5,401- 5,900	5,901- 6,400
7.....	0-5,000	5,001-5,500	5,501- 6,000	6,001- 6,500	6,501- 7,000

Class 1 families would not be subject to any cost sharing, Class 2 would pay only a hospital deductible, and Class 3 a deductible for various services but no coinsurance. Classes 4 and 5 would be subject to both deductibles and coinsurance. However, no cost sharing requirement would apply to maternity care, well-baby care, or family planning services.

Administration

The Department of Health, Education, and Welfare would be responsible for general administration of the program including the determination of eligibility and the regulations, standards, and hearings procedures for the program. As under the Medicare program, private insurance carriers under agreement with the Department would act as fiscal agents for payment of claims for services, and State agencies would determine whether providers of services qualify for participation in the program.

At their option, States could establish supplemental benefit plans to provide benefits additional to those under the national program. The Department would administer these plans on behalf of the State, if the State wishes. In this case, the State would pay the cost of its benefits and the Federal Government would pay the administrative cost.

Eligible families under the program would have the option of enrolling in a health maintenance organization.

Financing

The Family Health Insurance Plan would be financed by premium payments from those enrolled families required to pay premiums, and from Federal general revenues.

The amount of the annual premium payment would depend on the class of the family, as described above. The lowest income class (Class 1) would pay no premiums. For others, the premium is shown as follows:

Income class 2	$25
Income class 3	50
Income class 4	75
Income class 5	100

Premium payments could be deducted from the cash benefits payable under the FAP program, the social security program (OASDI), or a State program supplemental to FAP.

Persons who enroll with a health maintenance organization would be required to pay the same premium (if any) for the specified benefits. If the organization provides additional services, or reduces or eliminates the deductible and coinsurance, it may charge an additional reasonable premium.

PROVISIONS AFFECTING ALL PLANS

Relationship to Other Government Programs

The Medicare program would continue to operate; persons age 65 and over entitled to Medicare benefits would not be eligible under the employer or FHIP plans. The Medicaid program would be limited to the aged, blind, disabled, and children in foster care. Most other government programs would not be affected.

Standards for Providers of Services

Providers of service would have to meet the same standards as under the Medicare program (see page 117).

Professional Standards Review Organizations

The bill would apply the provisions of the Professional Standards Review Organizations (PSRO) for Medicare and Medicaid to the required employer plans and FHIP program. The PSRO programs establish boards of physicians at the local level to review the quality and appropriateness of services provided.

Reimbursement of Providers of Services

Institutions

Payment to hospitals, extended-care facilities, and home health agencies would be based on the "reasonable cost" of services, as under the Medicare law.

Physicians and Other Suppliers

Payments to physicians, dentists, and other health care personnel and suppliers would be based on the "reasonable charges" for their services, as under the Medicare law. However, under the FHIP program, physicians and others would have to accept the reasonable charge as their full payment (and could not make additional charges to the patient).

Health Maintenance Organizations

Under the employer plan, health maintenance organizations (HMO's) would be paid on a per capita basis for persons enrolled (as negotiated between the employer and the HMO). Under the FHIP program, HMO's would be paid a prospective per capita rate equal to 95 percent of the estimated amount needed if the services were furnished by other providers in the area.

The HMO could make various arrangements to reimburse its physicians. The physicians could be employees or partners of the HMO, or the organization could make arrangements with physician groups which, in turn, would pay the individual physicians on a fee-for-service or other basis.

Special provisions relating to the rate of retention (the organization's revenue minus its expenses) require that the retention applicable to the FHIP enrollees must be slightly less (90 percent) than the retention rate applicable to other groups enrolled in the organization. Any excess amount must be used to provide additional benefits or reduce premium rates for FHIP enrollees.

Delivery and Resources

Health Maintenance Organizations

Provision is made for health maintenance organizations--public or private organizations which provide health services to enrollees on a per capita prepayment basis--to participate in the program. As described previously, persons under both the employer and FHIP plans would have the option of enrolling with an HMO. The organization would have to meet the following requirements:

(1) provide all of the services and benefits covered under the program, either directly or under arrangement with others;

(2) assure that health services are furnished promptly and appropriately;

(3) utilize institutions, facilities, and health care personnel that meet the standards of the Medicare program, and any additional quality standards established by regulation;

(4) demonstrate it is financially responsible and capable of providing comprehensive health care services efficiently and economically;

(5) have not less than 10,000 enrolled members (this requirement may be delayed up to 3 years if the HMO is making progress to reach this number); it also may be waived (for an indefinite period) if, because of geographical location or other circumstances beyond its control, the HMO is unable to comply;

(6) if participating in the FHIP program, at least half of its members have to be persons not covered under FHIP or Medicaid;

(7) have an open enrollment period at least every year; and

(8) permit the Department, or its designee, to evaluate the services and records of the HMO.

Any State law or regulation which prevents an HMO from carrying out its agreement with the Department under FHIP would be inapplicable, as would any State law or regulation that limits a physician affiliated with an HMO from delegating certain duties to appropriate personnel.

Health Planning

The bill would impose the same provisions imposed under Medicare and Medicaid, limiting reimbursement to providers of services in connection with their capital expenditures, if these expenditures are not in conformity with the comprehensive plan of a State or areawide planning agency. These provisions were contained in recent legislation, P.L. 92-603 (H.R. 1).

TABLE 1.--RAILSBACK BILL: Benefit provisions under the Family Health Insurance Plan

Type of service	Benefits	Cost sharing for income class 1/				
		1	2	3	4	5
Institutional services						
Hospital:						
Inpatient	30 days per year.					
Room and board	See above	None	1-day deductible	1-day deductible	1-day deductible	2-day deductible.
Other services	See above	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Outpatient	No limit	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible 25% coinsurance.
Extended-care facility	3 days in an extended-care facility substituted for 1 day of hospital care.					
Room and board	See above	None	2-day deductible	2-day deductible	2-day deductible	4-day deductible.
Other services	See above	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 10% coinsurance.
Personal services						
Physicians' services: 2/ In hospital, extended-care facility, or while receiving home health services.	No limit	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Outpatient, home or office 3/	8 visits per year	None	None	$50 deductible, 10% coinsurance.	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.

See footnotes at end of table.

TABLE 1.--RAILSBACK BILL: Benefit provisions under the Family Health Insurance Plan--Continued

Type of service	Benefits	Cost sharing for income class 1/				
		1	2	3	4	5
Personal services--Con.						
Physicians' services:2/--Con.						
Emergency services	No limit	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Maternity care	No limit	None	None	None	None	None.
Family planning	No limit	None	None	None	None	None.
Periodic examinations3/	Birth-6 mos., 6 exams.; 7 mos.-2 yrs., 6 exams.; 2-5 yrs., 3 exams.	None	None	None	None	None.
Eye examinations	Children under age 12, 1 exam. per year.	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Home health services	7 days of home health services substituted for 1 day of hospital care.	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Laboratory and X-ray	No limit	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Outpatient physical therapy services	No limit	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Other services and supplies						
Medical supplies and appliances	No limit	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Ambulance services	Emergencies only	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Prosthetic devices	Emergencies only	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.

1/ The $50 and $100 deductible is the total annual amount payable per family for all services subject to deductibles.

2/ Psychiatric services excluded.
3/ Includes preventive care, immunizations, and checkups.

BURLESON-MCINTYRE BILL

The "National Health Care Act of 1973" was introduced by Representative Omar Burleson of Texas as H.R. 5200 and Senator Thomas J. McIntyre of New Hampshire as S. 1100. It is supported by the Health Insurance Association of America.

General Concept and Approach

The bill provides three voluntary health insurance plans to make coverage available to the entire population. The plans include: (1) an employee-employer plan, (2) an individual plan, and (3) a plan for the poor and uninsurable. All plans would provide after a phasing-in period a broad range of medical care services, with benefits generally subject to cost sharing by the patient. Also, all plans would be administered through private insurance carriers and supervised by the State and Federal Governments. The employee-employer plan and the individual health plan would be financed by premium contributions, and contributors would receive tax advantages. The plan for the poor would be financed mainly by Federal and State general revenues. The bill includes provisions designed to increase the supply of health manpower, the development of ambulatory care centers, the expansion of health planning, and the improvement of cost controls.

EMPLOYEE HEALTH CARE PLAN

The employee health care plan would, through use of the tax mechanism, encourage employers to provide qualified health insurance plans with specified benefits for employees and their dependents. Private insurance carriers would collect the premiums and process the claims for benefits. The premiums would be paid by the employer and employees. The plan would be supervised by State insurance departments. The Federal Government would determine the status of a plan under the tax laws.

Coverage of the Population

Persons working for employers who voluntarily establish a qualified plan would be covered. Such a plan must cover all full-time and part-time employees (who work at least 20 hours a week for at least 26 weeks during the year) and their dependents. New employees must be covered within 3 months. Coverage under the plan would continue, as follows:

(1) 2 months after termination of employment;

(2) 12 months during a layoff or labor dispute, if the employee pays the employee contribution for the first month and the total employee-employer contributions for later months;

(3) 30 months if absent because of illness or disability;

(4) 2 months of coverage for the surviving family in case of the employee's death.

Benefit Structure

Under present law, an employer may take the full cost of his premium contributions for health insurance as a business deduction for tax purposes. Under the bill unless an employer has a qualified plan, the premium cost would not be an allowable deduction, beginning in the third year after enactment of the bill (in the first year, 50 percent would be deductible and in the second, 25 percent). If a medical care plan established through a collectively bargained agreement was in effect when the program started, this provision would not apply until the expiration of the agreement, but not later than 3 years after the program started.

In addition, under present income tax law, employees and other persons who itemize their deductions on their individual income tax returns may deduct one-half of the premiums for private health insurance up to a maximum of $150, with the remainder deductible only to the extent that total medical expenses exceed 3 percent of adjusted gross income. Under the proposal, the employees who itemize may take their entire contributions toward a qualified plan as a medical expense deduction.

The required standard health care benefits are shown in table 1. (Table 1 begins on page 63.) These benefits would be phased in, with priority I benefits becoming available at the start of the program; priority II, 5 years later; and priority III, 5 years thereafter. Under a "catastrophic expense" provision applicable during the phasing-in period, a person who incurs $5,000 in covered medical expenses would automatically become entitled to priority III benefits (subject to a lifetime maximum of $250,000). If the health council (established under the bill) advises that facilities and services are not available, the President may defer the phasing in of benefits.

In lieu of the specific dollar copayments applicable to various services, coinsurance up to 20 percent may be required (except where a higher coinsurance percentage is specified in table 1). Also, in addition to the other requirements, an annual deductible of up to $100 per family may be imposed, but the deductible for a service cannot be larger if given on an ambulatory basis than in an institution. The total

payment for a family for all cost sharing (deductibles, copayments, and coinsurance) is limited to $1,000 in a year.

The plan may provide benefits in addition to those required under a qualified policy.

Administration

Employers would purchase qualified policies from private insurance companies which would collect the premiums and process the claims for benefits. The policies must be approved by the State insurance department as satisfying the requirements for a qualified policy. The Department of the Treasury may accept the approval of the State insurance department in determining the tax status of the premiums for income tax purposes.

Under provisions designed to protect against insolvency, carriers underwriting insurance under the program are required to have a combined capital and surplus of $1.5 million. As an alternative, the requirement can be met by securing a performance bond or contracting with another carrier to assure continued coverage in event of failure.

In addition, companies are required to maintain a "NHI contingency reserve" equal to its current liabilities (for claims and related expenses) plus 12-1/2 percent of the amount of claims paid in the previous year. The companies must file annually with the State insurance commission a statement of its NHI reserves and its financial condition. A company not meeting the requirements would be considered "impaired." Such a company must meet special conditions and submit a plan to the insurance commission for meeting its obligations and, if this plan is disapproved, an additional plan for review by a special committee of representatives of the insurance industry. This committee may decide that an assessment on other participating carriers is necessary to raise the necessary funds and, if so, the assessment would be made on a State basis, charged separately to either commercial insurers or Blue Cross-Blue Shield insurers (depending on which type of insurer has failed).

Financing

The premiums for an employee plan would be paid by employers to the insurance carrier. As arranged between employers and employees, the employees may be required, without limitation on the amount, to contribute to the premiums, except that the amount of the employee's contribution would be limited to 10 percent of his monthly wages over the following amounts:

Individual	
Family, with one dependent	$167
Family, with two dependents	250
	333

For example, the maximum contribution for an employee with one dependent earning $300 monthly would be $5 (10 percent of $50).

INDIVIDUAL HEALTH CARE PLAN

The individual health care plan would provide income tax incentives to encourage the purchase of individual (nongroup) qualified insurance providing specified health insurance benefits. The premiums would be paid by the policyholder. The State and Federal Governments would have supervisory responsibilities similar to those under the employee plan.

Coverage of the Population

All persons would be eligible to voluntarily purchase a qualified individual health care policy for themselves and their families. This plan would make qualified insurance available to self-employed persons and others not eligible under the employee or State plans.

Benefit Structure

Persons purchasing a qualified individual policy may, if they itemize their deductions on their personal income tax return, take the entire premium cost as a medical expense deduction (as explained previously for employee contributions toward a plan).

The medical care benefits of an individual policy are identical to those under the employee plan and would be phased in at the same time (table 1). As in the employee plan, coinsurance up to 20 percent may be substituted for the copayments applicable to the various benefits and an additional deductible may be imposed (which must not be larger for ambulatory than for institutional care). For an individual plan, no limit is placed on the amount of this deductible or on the total amount of cost sharing that could be required in a year.

The policy could include benefits in addition to those required under a qualified policy.

The insurance policy must be renewable, but the insurance carrier may adjust the premium rates for a class of policies according to the experience for that class. Coverage under the policy ends when the policyholder becomes covered under another type of qualified policy or becomes eligible for Medicare benefits.

Administration

The individual would purchase the insurance from a private insurance carrier. Policies must be approved by the State insurance department as being qualified and the Treasury Department may accept this approval in determining the tax deductibility of the premium cost. The provisions regarding insolvency also apply to individual policies.

Financing

The policyholder would pay the entire premium cost to the insurance carrier.

STATE HEALTH CARE PLAN

The State health care plan is designed to provide the standard benefits for the needy, the uninsurable, and certain others. It would be administered by a private insurance carrier (or group of carriers) in each State and financed by premium payments from covered persons and contributions from State and Federal general revenues.

Coverage of the Population

Coverage under the State health care plan would be available to various groups of persons, if not eligible under a qualified employee plan, as indicated below.

(1) Needy persons.--Individuals and families could voluntarily enroll in the State plan if their adjusted gross income for income tax purposes was less than the following annual amounts:

Individual	$4,000
Family of two	6,000
Family of three or more	8,000

Eligibility could also be met on a monthly basis, if income for each of the last 2 months was below the following amounts:

Individual	$83
Family of two	125
Family of three or more	166

Public assistance recipients would be eligible for coverage under the State plan without regard to their actual income.

(2) Uninsurable persons.--Coverage under the State plan would be available on a voluntary basis to persons who cannot obtain a qualified individual policy because they are uninsurable (usually because of poor health). The person is considered uninsurable if he applies to three insurance carriers who either refuse to issue a policy or offer one at a premium cost greater than twice that of the State plan.

(3) Special groups.--Groups of persons who are receiving substantially all their medical care under a Federal or State program may be enrolled as a group under the plan. (These could include, for example, dependents of servicemen and inmates of an institution.) Under this provision (which does not apply to public assistance recipients as a group) the Federal or State Government would pay the entire premium for the group.

Enrollment

Families and individuals may voluntarily enroll by filing application with an administering carrier during an open enrollment period each year. Those becoming eligible later may apply within 30 days of their eligibility. Public assistance cash recipients must be enrolled by the State public assistance agency. Coverage for all enrollees continues for the balance of the policy year regardless of change in the eligibility status of an individual family member.

Benefit Structure

The proposed law does not directly require a State to establish a health care plan. It permits payment of benefits under a State plan beginning July 1974 and requires, in this case, that priority II benefits be paid initially and priority III benefits beginning July 1979. (As indicated on page 59, the Medicaid program would be limited to noncovered benefits beginning July 1975.) A delay by the President in the phase-in of benefits would also apply to these benefits, as described earlier.

The same cost-sharing requirements applicable to the other plans apply to the State plan, but special provisions limit the total amont of cost sharing to $50 in a year for needy persons having adjusted gross income less than the specified amounts shown as follows:

Individuals	$2,000
Family of two	3,000
Family of three or more	4,000

For those with higher income, the maximum amount of cost sharing would be limited to 10 percent of their income over these specified amounts (but not less than $50). For example, a family of three or more with income of $5,000 would pay a maximum of $100 (10 percent of $1,000).

The State plan could provide benefits in addition to the standard benefits, but the Federal Government would not share in the cost of additional benefits.

Administration

The State plan would be administered by an insurance carrier under an agreement between a State and the carrier, with the approval of the Department of Health, Education, and Welfare. The administering carrier could be a commercial insurance company, a service benefit organization, or any of several other types. The administering carrier would determine eligibility for enrollment in the plan, collect the premiums and government contributions, process claims for benefits, pay providers of services, and administer the State plan insurance pool. Individuals and families enrolled in the plan would be issued health insurance policies.

The operation of the plan would be under the supervision of the State insurance department, and payment to providers would need to meet the standards of the State cost commission.

At the Federal level, the Department of Health, Education, and Welfare would issue regulations for operation of the plan. These regulations would need to be issued in final form at least 9 months before the policy year to which they apply.

As a condition of receiving Federal Government contributions for the State plan, the State must agree that it will not impose a premium tax or similar tax on the State plan, and that it will levy taxes on health insurance business in the State equally on all carriers.1/

Financing

The State plan would be financed by premium payments of enrolled families, graduated according to income, and by contributions from State and Federal general revenues.

The amount of the full premium would be determined by the administering carrier. The full premium would be an amount actuarially sufficient to meet the total cost of the program. The premium amount would be based on the previous year's experience (adjusted for estimated increase in costs) and would include an allowance for the benefit cost and for costs

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1/ In many States, Blue Cross and Blue Shield are exempt from premium taxes and other taxes applicable to other carriers.

of administration, and a risk charge equal to 1 percent of the benefit cost. It would also include an allowance for repayment in full of State insurance pool losses to reinsuring carriers for past years.

The premium rates determined by the carrier would be reviewed by the Chief Actuary of the Social Security Administration, who could recommend a reduction to the Department of Health, Education, and Welfare. If so, at the request of the State, a hearing would be held before a board of three actuaries appointed by the Department (including one with the concurrence of the State and one with the concurrence of the carrier). If the hearing board determined the premium rates were too high, the Federal contributions to the State plan could be reduced.

Contributions of Policyholders

Policyholders would pay a premium based on their adjusted gross income. Needy persons under the State plan would not pay any premium if their income for the year was below the amounts specified below:

Individuals	
Family of two	$2,000
Family of three or more	3,000
	4,000

Those with income above the specified limit would pay 10 percent of the amount above this limit. For example, a family of three or more with an income of $5,000 would pay $100 (10 percent of $1,000) toward the premium.

For those eligible on the basis of the monthly income test, the monthly premium would be:

Individuals	
Family of two	$16.67
Family of three or more	25.00
	33.33

Uninsurable persons would pay the full actuarial premium rate. The State and Federal Governments would pay the rest of the premiums of the State plan--in effect, the premiums for those who do not contribute and the balance of the premiums for those who pay part. Thus, the plan would receive a full premium for all enrolled persons. The Federal share of the total government contribution would be 70 to 90 percent, depending on the per capita income of the State.

State Insurance Pool

The premiums and other income of the plan would be deposited in a State insurance pool from which all benefits and expenses of the plan would be paid. The pool would be reinsured by all health insurance carriers licensed in the State and if the pool suffered a loss in the year, the

loss would be borne by the carriers according to an agreed formula, up to a maximum of 3 percent of premiums. (As indicated previously, carriers would later be reimbursed for any losses they have borne.) Any additional loss would be absorbed by the State and Federal Governments (according to the sharing formula). If the pool showed a gain, it would be retained by the pool and used to reduce the State's future premium contributions to the pool.

Provisions For the Aged

Persons age 65 and over could be covered under the State plan under special provisions applicable to that group. Aged persons must be enrolled in the voluntary supplementary medical insurance plan (Part B) of Medicare to be eligible for State plan coverage. If their income is above the specified limits, so that they would be required to pay premiums, the amount of the premium would be reduced by the amount of the Part B premium. If their income is below the specified limits, the State would pay the Part B premium on their behalf from State general revenues. The Medicare program would continue to operate and would have initial liability in paying for services.

PROVISIONS AFFECTING ALL PLANS

Relationship to Other Government Programs

As indicated, the Medicare program would continue to operate. The proposal specifies that, effective July 1975, the Medicaid program would not pay for medical services provided under a State plan, nor for cost sharing required by the plan. Most other government programs would not be affected.

Standards for Providers of Services

Institutions

Health care institutions (hospitals, skilled nursing facilities, and home health agencies) would have to meet the same standards as under the Medicare program (see page 117).

Health Maintenance Organizations

Health maintenance organizations which furnish health care services to enrollees on a per capita prepayment basis would be required to meet quality standards established by regulation.

Physicians and Dentists

Physicians and dentists would have to be legally authorized to render services by the State in which they provide their services.

Reimbursement of Providers of Services

Institutions

Payments to health care institutions (hospitals, skilled nursing facilities, and home health agencies) would be based on prospectively approved rates for different categories of institutions. Institutions would be required to prepare a budget, based on a standard accounting system, and recommend a schedule of charges which would apply to all patients. Annually, a State health care institutions cost commission, following its review of the budgets and proposed charges, would approve or disapprove the rates.

The charges for services would need to be reasonably related to the cost of efficient production of the services. In its review, the commission would take into account economic factors in the area, costs of comparable institutions providing comparable services, capital requirements, and the need for incentives to improve service and institute economies.

The State commission could approve the use of a single charge for a group of services commonly rendered to a class of patients, or a single all-inclusive daily charge for all inpatient services. The level of rates approved for different categories of institutions would be reviewed by the Department of Health, Education, and Welfare. If the Department determined the rates for a given category were unjustifiably high in relation to other States, Federal funds for Medicaid and for the State plan under this proposal would be reduced.

Health maintenance organizations would be paid on the basis of per capita charges, which could not exceed the regular premiums for the plan.

Physicians and Dentists

Payment to physicians, dentists, and other health-care personnel would be based on reasonable charges, taking into account the customary charge of the practitioner and the prevailing charge in his locality. Payment could not exceed the prevailing charge (which would be set at the 75th percentile of the distribution of actual charges made for similar services during the previous year).

Other Government Programs

Payments to providers for reasonable costs or reasonable charges under the Medicare, Medicaid, and maternal and child health programs could not exceed the reasonable cost or charge as determined under the proposal.

Health Maintenance Organizations

Provision is made for health maintenance organizations--organizations which provide health care services to enrollees on a per capita prepayment basis--to participate in the program. A health maintenance organization would have to provide--either directly or under arrangements--all of the standard health care benefits.

The State plan and employee plans must make health maintenance organizations available as an option for those enrolled in the plans, assuming an HMO was available in the area. For an individual plan, the policyholder could select a health maintenance organization.

Comprehensive Ambulatory Health Care Centers

The bill includes provisions designed to encourage development of comprehensive ambulatory health care centers. These are facilities (located in or apart from a hospital) that are organized to provide a broad range of ambulatory health services and that have the following services and facilities:

(1) Medical, surgical, and preventive care services, including health education.

(2) Arrangements for treatment at a general hospital and other institutions when inpatient care is needed.

(3) Operating and recovery rooms.

(4) Laboratory and X-ray facilities.

(5) Unified medical records.

(6) Peer review programs.

(7) A plan to use allied health personnel.

Grants, loans, and loan guarantees are authorized for the construction or modernization of centers in areas designated by the State comprehensive health plan, and to pay their operating deficits for the first 3 years of operation. Priority would be given to putting facilities in densely populated areas where none exist. Special project grants are authorized for training personnel to staff the centers.

Health Planning

(1) A council of health policy advisors to the President would be created for the purpose of (a) recommending improvements in the organization, financing, delivery, and quality of health care; (b) recommending guidelines for the allocation of funds for health care; and (c) appraising Federal health programs and recommending procedures for interagency coordination.

(2) The bill increases appropriations under existing Federal programs for grants for comprehensive health planning at the State and local level and expands the scope of planning agency responsibilities.

(3) Comprehensive health planning agencies would have to certify as to the need for the health project before grants, loans, and other financial aid in excess of $100,000 could be made under Federal programs.

Health Manpower

(1) The bill expands the student loan provisions of the Public Health Service Act for training in the health professions (physicians, dentists, pharmacists, etc.) by increasing to $5,000 the dollar limit for an academic year for tuition and fees, room and board, supplies, books, and other related costs.

(2) Similar loans up to $3,500 are provided for the training of nurses.

(3) Similar loans are provided for training in the allied health professions, without any dollar limit on the amount of the loan. If the person after graduating is employed full-time in these occupations, 20 percent of the loan may be cancelled each year (up to 50 percent of the total loan). If employed in a shortage area, one-third of the loan may be cancelled each year (up to 100 percent of the total loan). The bill also provides for scholarship grants to students training in allied health professions, covering the full cost of tuition and other student expenses.

(4) Grants are provided to trained health professionals, allied health professionals and nurses for serving in areas of critical need for at least 2 years. These individuals would receive guaranteed income payments equal to 110 percent of the annual median income for persons of comparable education and training, or 110 percent of their own earnings in the previous year, whichever is greater.

(5) Special project grants are provided to schools of medicine, training centers for allied health professionals, and other educational institutions to develop and evaluate curriculums to train and coordinate teams of personnel to staff ambulatory health care centers.

TABLE 1.--BURLESON BILL: Standard health care benefits

Benefit	Cost sharing	Benefits and effective date		
		Priority I	Priority II	Priority III
		Private plans 1/75	State plans 7/74 Private plans 1/80	State plans 7/79 Private plans 1/85
Institutional Services				
Hospital inpatient 1/	$5 per day	30 days per illness	120 days per illness	300 days per illness.
Extended care: Inpatient 1/	$2.50 per day	60 days per illness	120 days per illness	180 days per illness.
Personal Services				
Physicians' services:2/				
In hospital	$2 per day	30 days	120 days	300 days.
	$5 per day	After 30 days	After 120 days	After 300 days.
In skilled nursing facility	$2 per day	60 days	120 days	180 days.
	$5 per day	After 60 days	After 120 days	After 180 days.
Office visits:3/				
Diagnosis or treatment	$2 per visit (mental--50 percent after 6th visit).	3 visits per year	6 visits per year	No limit.
Surgery and radiation therapy	$2 per visit	No limit	No limit	No limit.
Laboratory and X-ray	None	No limit	No limit	No limit.
Family planning	None	No benefit	No limit	No limit.
Periodic exams:				
Under age 5	None	6 exams (birth to 6 months)	6 exams (age 7 months to 2 years).	3 exams (age 2 to 5 years).
Age 5 to 39	None	No benefit	No benefit	1 exam. every 5 years.
Age 40 and over	None	No benefit	No benefit	1 exam. every 2 years.
Eye examinations:				
Under age 19	None	No benefit	No benefit	1 exam. per year.
Age 19 and over	50 percent	No benefit	No benefit	1 exam. every 3 years.
Home visits	$5 per visit (mental 50 percent).	No benefit	No benefit	No limit.

See footnotes at end of table.

TABLE 1.--BURLESON BILL: Standard health care benefits--Continued

Benefit	Cost sharing	Benefits and effective date		
		Priority I	Priority II	Priority III
		Private plans 1/75	State plans 7/74 Private plans 1/80	State plans 7/79 Private plans 1/85
Personal Services--Continued				
Dentists' services:				
Examination:				
Under age 19	None	No benefit	1 exam. per year	1 exam. per year.
Age 19 and over	None	No benefit	No benefit	1 exam. per year.
Fillings, extractions, and dentures:				
Under age 19	20 percent	No benefit	No limit	No limit.
Age 19 and over	20 percent	No benefit	No benefit	No limit.
Other (excludes orthodontia)	50 percent	No benefit	No benefit	No limit.
Home health services	$2.50 per day	90 days	180 days	270 days.
Independent laboratory	None	No limit	No limit	No limit.
Optometrist, eye examination	Same as eye examinations shown under physicians services above.			
Physical therapy	20 percent	No benefit	No limit	No limit.
Speech therapy	20 percent	No benefit	No benefit	No limit.
Other Services and Supplies				
Prescription drugs	$1 per prescription	No benefit	No limit	No limit.
Prescription contraceptives	$1 per prescription	No benefit	No limit	No limit.
Prostheses 4/	20 percent	No benefit	No limit	No limit.
Eyeglasses:				
Under age 19	None	No benefit	No benefit	1 pair per year.
Age 19 and over	50 percent	No benefit	No benefit	1 pair in 3 years.
Pregnancy: Physicians' services, hospital, skilled nursing facility, independent laboratory, home health services.5/	20 percent	From beginning of pregnancy to 30 days after birth.		
Catastrophic expense benefits	For persons who incur $5,000 in medical expenses, priority III benefits always applicable.6/			

1/ 2 (or more) separate stays considered a single period of illness unless separated by 60 days or more.

2/ Includes services of Christian Scientist practitioners, and podiatrists in certain capacities (routine foot care is excluded).

3/ Includes services rendered in hospital outpatient department.

4/ Hearing aids excluded.

5/ Priority II benefits always apply to these services.

6/ See page 52.

FUQUA BILL

The "National Health Care Act of 1973" was introduced by Representative Don Fuqua of Florida as H.R. 559. It is identical to H.R. 4349 introduced by Representative Omar Burleson in the 92d Congress. Representative Burleson has introduced a revised bill, H.R. 5200, supported by the Health Association of America, discussed previously.

The major revisions in the current Burleson bill (which distinguishes it from the old Burleson and the current Fuqua bills) are as follows:

EMPLOYEE HEALTH CARE PLAN

(1) The provisions for continuation of family health insurance coverage of employees in event of termination of employment, absence because of illness or disability, or death of the employee, are changed.

(2) The provision concerning the disallowance of medical expense premiums as a business expense deduction for tax purposes, where a business has a nonqualified health plan, has been revised to eventually eliminate the deduction.

(3) The types and amounts of hospital and medical benefits are phased in over a longer period than the earlier bill and a catastrophic expense benefit, which is applicable temporarily during the phasing-in period, has been added.

(4) Certain services of Christian Science practitioners and podiatrists are covered.

(5) The States are required to monitor the financial soundness of insurance carriers, and to assess all participating carriers in the State to protect against the possible insolvency of a carrier.

(6) The amount of the employee contribution toward the health insurance premium, previously unlimited, is limited to 10 percent of his wages over specified amounts.

STATE HEALTH CARE PLAN

(7) The annual income limits for eligibility for the State health plan for the medically needy have been raised. Also, eligibility may now be met according to a monthly income test.

(8) The rate of cost sharing (deductibles and coinsurance and copayments) and the maximum cost sharing amount, for the medically needy group, is raised.

(9) A monthly premium is established for families eligible for benefits based on the monthly income test (see item 7).

PROVISIONS AFFECTING ALL PLANS

(10) The annual amount of the loan available to a student for training in the health professions and in nursing is limited to specified maximums. Previously, no limit was indicated.

JAVITS BILL

The "National Health Insurance and Health Services Improvement Act of 1973" was introduced by Senator Jacob K. Javits of New York as S. 915.

General Concept and Approach

The bill would establish a national health insurance program based on an expansion of the Medicare program to the general population. The proposal would provide a broad range of medical benefits to all U.S. residents, following a "phasing-in" period. Benefits would generally be subject to cost sharing by the patient. The program would be financed by payroll taxes and general revenue contributions, and be administered by the Federal Government. Options would be available to obtain approved alternative coverage under private insurance outside the Government program. The bill includes provisions to encourage the formation of comprehensive health service systems.

Coverage of the Population

The first groups to become eligible at the start of the program would be U.S. citizens aged 65 and over (and aliens aged 65 and over residing in the U.S. for at least 5 years, or eligible for social security benefits). Persons of any age entitled to social security disability benefits would also be covered.

In the second stage, 2 years later, coverage would be extended to all persons not previously covered who are resident U.S. citizens or aliens admitted for permanent residence. Persons would be eligible for benefits without regard to whether they have made contributions to the program.

Benefit Structure

In its final form, the proposal would provide the benefits of the present Medicare program and three new services: annual physical checkups, dental care for children under 8 years of age, and prescription drugs for chronic illness. The benefits of the proposal are as follows: Several types of services are subject to the present Part B provision of the Medicare law which requires a $60-annual deductible, per person, and a 20-percent coinsurance payment:

Institutional services

Hospital inpatient care: 90 days of inpatient hospital services per benefit period with a "lifetime reserve" of 60 additional days. (A 190-day lifetime limit applies to stays in psychiatric hospitals.) The patient pays the Medicare deductible in each benefit period and, in addition, a copayment for each day after the 60th. There would also be a copayment for each day of the lifetime reserve.1/

Hospital outpatient care: subject to Part B cost sharing.

Skilled nursing facility services: following a hospital stay, for 100 days per benefit period with copayment for days following the 20th.2/

Personal services

Physicians' services: subject to Part B cost sharing. Psychiatric physicians' services limited to a maximum annual payment of $250 for ambulatory care.

Physical checkups: annually, including eye and ear examinations and diagnostic tests, subject to a 20-percent coinsurance payment (with no deductible). The amount of payment would be the smaller of $75 or the amount charged by the most efficient provider in the locality. The benefit would begin 3 years after the start of the program.

Dentists' services: routine dental care for children under age 8. Orthodontia is excluded. Payment is subject to 20-percent coinsurance (with no deductible). Coverage would begin 3 years after the start of the program.

Home health services: 100 post-hospital home health visits per benefit period, without deductible or coinsurance under Part A and 100 visits under Part B, with no coinsurance.

1/ The Medicare deductible in 1972 was $72. The coinsurance rates, which are related to the deductible, are one-quarter of the deductible ($18) after the 60th day, one-half the deductible ($36) for the lifetime reserve, and one-eighth ($9) for skilled nursing facilities. The amount of the deductible is changed each January if the average per diem rate for hospital care rises.

2/ *Ibid.*

Laboratory and X-ray: subject to Part B cost sharing.

Outpatient physical therapy services: subject to Part B cost sharing.

Other Services and Supplies

Medical supplies and appliances, and ambulance service: subject to Part B cost sharing.

Prescription drugs: maintenance drugs for the treatment of chronic diabetes, cardiovascular diseases, and kidney and respiratory conditions. There would be a $1 charge per prescription and this amount would be adjusted in future years according to changes in the per capita cost for drugs. The benefit would begin 1 year after the start of the program.

Administration

As under the Medicare program, the Department of Health, Education, and Welfare would be responsible for general administration of the program, including the regulations and standards for the program. Private insurance carriers under agreement with the Department would act as fiscal intermediaries for payment of claims for services, under standards established by the Department. If the Department determined that the fiscal intermediary in an area has not performed its duties adequately, a federally chartered quasi-governmental corporation could be established to replace the intermediary.

State agencies would continue to determine whether providers of services meet the conditions for participation in the program. The Health Insurance Benefits Advisory Council would be retained to advise the Department on policy and administrative matters.

The bill also authorizes the Department to make agreements with States to administer the entire program on behalf of the Department.

Optional Alternatives to the Government Program

The bill automatically covers all eligible persons under the Government program unless they are covered under an approved alternate private insurance plan.

Employer-Employee Health Plan Option

An employer by contract with the Department could establish for his employees a qualified plan which meets the following requirements:

(1) health benefits are provided through an insurance carrier or a union-management health and welfare plan,

(2) all employees and their dependents are covered,

(3) the employer pays at least 75 percent of the cost,

(4) the benefits are superior to those under the Government program,

(5) hearings are available for dissatisfied claimants, and

(6) methods of payment of physicians are the same as under the Government program.

Employers and employees covered under an approved plan would be exempt from the regular insurance tax.

Private Health Insurance Option

Private carriers by contract with the Department could offer alternative health insurance policies, which meet the following conditions:

(1) the insurance is offered to all living in a specified area,

(2) the selection of policyholders meet regulations concerning selection of risks,

(3) benefits are equal to those furnished under the Government program and the cost is no greater,

(4) premiums for additional (noncovered) benefits are reasonable, and

(5) hearings are available for dissatisfied claimants.

The bill does not specifically exempt persons under an approved private insurance plan from payment of the health insurance tax.

The bill provides for coverage under a comprehensive health service system for persons under the Government program who choose to do so. An approved employer-employee plan or an individual health plan may offer this option.

Relationship to Other Government Programs

The bill would, in effect, absorb the Medicare program and include its beneficiaries in the Government-administered program. Since the Javits proposal is based on the Medicare law, its relationship to other Government programs would be essentially the same as Medicare. In general, Medicare will not cover services paid by a Government entity, but exceptions can be made in certain cases. Arrangements have been made for Medicare to reimburse OEO and HEW community health centers for the cost of covered medical services and to pay providers for services rendered to persons eligible under the CHAMPUS program.

For State and local health programs, Government hospitals have been approved for payment and Medicare will pay for services which otherwise would be financed by vocational rehabilitation agencies.

In the case of Medicaid and the Maternal and Child Health Program, both of which are part of the social security legislation, the law specifically provides that Medicare would have initial liability in paying for services.

Financing

The bill would combine the Medicare supplementary medical insurance program (Part B) with the hospital insurance program (Part A), and thus eliminate the premium payments for supplementary insurance.

The Government program would be financed by a health insurance tax on wages and self-employment income, with additional contributions from Federal general revenues.3/ The tax rates are graduated over a 5-year period to meet the increasing financial needs as new benefits and additional persons are phased into the program. Contribution rates for employers and employees (and for self-employed persons) would be 0.7 percent of taxable wages for the first year of the program and would be increased each year, ultimately reaching a rate of 3.3 percent after 5 years.

3/ As noted previously, employers and employees covered under an approved employer-employee health plan would be exempt from the special health insurance tax.

The health insurance tax would apply to the first $15,000 of earnings of employees and the self-employed, and to the employer's total payroll. The contribution from Federal revenues would be an amount equal to 50 percent of receipts from the payroll tax (plus the additional amount that would have been received if no alternative employer-employee plans had been established).

Workers under social security and Federal, State, and local government employees would be subject to the tax. However, State and local governments would not pay the employer tax.

In effect, the program would be financed roughly one-third by employees, one-third by employers, and one-third by Federal general revenues.

Funds would be held in two accounts within a Federal health insurance trust fund. The "general account" would be primarily the existing Medicare trust funds for the aged, combining the hospital insurance and the supplementary medical insurance trust funds. This account would be used for the payment of benefits for the aged and the disabled. A "special account" would be established to pay the benefits for the remaining population.

Standards for Providers of Services

Standards of participation for providers of services would be the same as those of the Medicare program. The Medicare standards are shown on page 117. In addition, the Department would be authorized to adopt additional standards for physicians dealing with requirements for continuing professional education, national licensing, and qualifications to perform major surgery and specialist services. These standards could be established only after considering those established by professional organizations, and receiving the recommendations of the Health Insurance Benefits Advisory Council, and following public hearings.

Reimbursement of Providers of Services

In the first 2 years of the program, providers of services would be reimbursed as they are under the present Medicare law. Under Medicare, hospitals, skilled nursing facilities, and home health agencies are reimbursed for the "reasonable cost" of services. However, payment for medical services would be based on "appropriate and reasonable charges" rather than "reasonable charges."

The Department would be required, in the interim, to study alternative methods of reimbursement to determine those methods which would best

control costs and utilization, improve the organization and delivery of health services, and assure that providers receive fair and reasonable compensation. Another possible objective would be to encourage medical societies or other organizations to assume greater responsibility for the quality, utilization and efficiency of care provided by their members, as well as the continuing education of professional and paramedical personnel. Following its study, the Department (with Presidential approval) would issue regulations concerning new reimbursement methods which would take effect in the third year of the program.

Of course, reimbursement would be subject to the new provisions and limitations included in P.L. 92-603 (H.R. 1).

Comprehensive Health Service Systems

Payment to qualified comprehensive health service systems (which are discussed later) would be based on the reasonable cost of services or could be a capitation rate for persons enrolled in the comprehensive system. Additional incentive payments are authorized if the average cost of services is less than the average cost of a comparable population group. Incentive payments are limited to a maximum of two-thirds of this difference in cost per member.

Providers of Drugs

Payment to drug providers would be based on "reasonable" charges including acquisition and dispensing allowances as determined by regulation. The physician's prescription would be filed with the drug provider. For a nonlegend drug, the physician would be required to certify that it is medically necessary.

Delivery and Resources

The plan authorizes the Department to contract for health services with comprehensive health service systems. These systems could be prepaid group practice organizations, other providers of health services, health insurance carriers, or a combination of them.

A comprehensive health service system is defined as one which provides health care to an identified population in an area, directly or through contractual arrangements with other providers. It must furnish all services covered under the Government program without any cost sharing by the patient, and the following additional services: a full range of prescription drugs, skilled nursing services without regard to the requirement concerning prior hospitalization, and immunizations and other approved services. The system would also need to meet the following requirements:

(1) it must assure the availability of services to enrollees, continuity of care, and appropriate referral and transfer of patients;

(2) all persons in the area may enroll, and it would encourage enrollment from a broad range of socioeconomic groups;

(3) preventive health services and health education are provided;

(4) a committee of physicians is established to consult with membership representatives, fix the professional policies, supervise the delivery of services, and review the utilization of health services;

(5) employment and training are given to allied health personnel;

(6) the premiums charged for noncovered services are reasonable; and

(7) the system is approved by State and areawide health planning agencies.

Financial Assistance to Comprehensive Systems

The Department is authorized to provide loans, grants, and technical assistance to comprehensive health service systems as follows:

(1) Grants and technical assistance to pay 80 percent of the cost of planning a comprehensive health service system. (Application for these grants could be made by a hospital, school, an insurance organization, or a community group.)

(2) Grants of 80 percent of the non-Federal share (the funds that the sponsor of a project ordinarily contributes) required under the Hill-Burton program for construction of hospitals and medical facilities.

(3) Grants of 50 percent of the cost of construction of needed ambulatory-care facilities, and loans at 3 percent interest for the remaining cost.

(4) Payment of the operating deficit of an approved system during its first 5 years of operation, provided the organization is making reasonable progress toward becoming self-supporting.

(5) Special grants of 100 percent of costs, up to $100,000, would be available for planning comprehensive systems in poverty areas, or demonstration projects designed to develop new methods of delivering care.

GRIFFITHS-KENNEDY BILL

"The Health Security Act" was introduced by Representative Martha W. Griffiths of Michigan and Senator Edward M. Kennedy of Massachusetts as S. 3.

General Concept and Approach

The bill would establish a national health insurance program covering the entire population and providing a broad range of health services, with no payment required of the patient. The program would be financed by a Federal payroll tax on employers and employees, a tax on unearned income, and Federal general revenues. The program would be administered by the Department of Health, Education, and Welfare. The proposal includes provisions designed to reorganize the delivery of health services, improve health planning, and increase the supply of health care manpower and facilities.

Coverage of the Population

All residents of the United States would be covered, including aliens admitted as permanent residents or for employment. Alien residents employed by a foreign government or an international organization would be eligible for coverage under special agreements. Persons would be eligible for benefits without regard to whether they have contributed to the program.

Benefit Structure

Benefits would be as follows, with no limits on the amount of services, except as indicated, and with no cost sharing required:

Institutional Services

General hospital inpatient care.

Psychiatric hospital inpatient care: 45 consecutive days in a spell of illness.

Hospital outpatient care.

Skilled nursing home care: 120 days in a spell of illness; number of days may be increased, by regulation, for homes owned or managed by a hospital, and for all homes depending on the availability of funds.

Personal Services

Physicians' services (nonpsychiatric): Includes physical checkups, immunizations, well-child care, and family planning services.

Physicians' psychiatric services: 20 visits during a spell of illness, but without limit if furnished by a health maintenance organization (HMO), hospital outpatient department, or mental health clinic.

Dentists' services: In first year of program for children up to age 15 and, each year thereafter, extended to persons 2 years older (e.g., in the second year to age 17) up to age 25. Once eligible, coverage continues throughout lifetime. By regulation, coverage may be extended faster than indicated in the law. Within 7 years after enactment, a timetable for phasing-in the entire population must be established. In extending coverage, preference may be given (temporarily or permanently) to enrollees of approved HMO's and organized dental plans.

Podiatrists' services.

Home health services.

Laboratory and X-ray.

Other personal services: Psychological, physiotherapy, nutritional, social work, health education, and related services furnished by an institution, HMO, or other agency under contract.

Other Services and Supplies

Optometrists' services and eyeglasses: By regulation.

Medical appliances: Therapeutic devices, appliances, and equipment, as established by regulation. Expenditures to be limited to 2 percent of total expenditures of program, if possible.

Ambulance services: By regulation.

Prescription drugs: Drugs required for chronic conditions and for specified conditions involving financial hardship, but without this limitation if provided by an HMO or professional foundation.

Experimental services which, because of cost or shortages, could not be provided on a nationwide basis would be excluded.

Administration

The program would be administered by the Department of Health, Education, and Welfare. A 5-member, full-time health security board, appointed by the President with the consent of the Senate, would serve under the Secretary of Health, Education, and Welfare. Board members would have 5-year overlapping terms and no more than three could belong to the same political party. The board would be responsible for general administration of the program including policy and regulations, control of expenditures, and standards and reimbursement for providers of services.

A national advisory council, appointed by the Secretary, would advise the health security board on general policy, regulations, and allocation of funds. The council would include the chairman of the health security board and 20 members including representatives of consumers (who would constitute a majority) and of providers of services. A commission on the quality of health care would be established in the Department to recommend to the Secretary and the health security board standards relating to the quality of care.

The program would be administered through the regional offices of the Department and local health service areas. Regional and local advisory councils, comparable to the national advisory council, would advise the regional and local offices. Individuals or providers with grievances would be entitled to hearings, appeals, and judicial review in Federal courts.

Relationship to Other Government Programs

The Medicare program for the aged would be abolished. The Federal Government would not financially participate in the cost of covered services for the Medicaid, vocational rehabilitation, and maternal and child health programs. (The intent of this provision is that these programs not pay for covered services.) Services under the CHAMPUS program (for military dependents and retirees) would be limited to non-covered services.

Federal providers of services including the Department of Defense, Veterans Administration, and the Department of Health, Education, and Welfare facilities for merchant seamen, Indians and Alaskan natives would not be eligible providers under the national plan. OEO and HEW health centers would be eligible providers. Agencies providing school health services would also be eligible for reimbursement. Medical services under a Federal or State's workmen's compensation law are not affected by the proposal. The bill requires a study of methods of coordinating HEW and the veterans programs with the proposed plan.

Financing

The program would be financed by (a) a 1.0-percent tax on wages of employees and on unearned income, (b) a 3.5-percent tax on employers' payrolls, (c) a 2.5-percent tax on self-employment earnings, and (d) contributions from Federal general revenues equal to the total receipts from taxes. If a firm's current obligations for health benefits exceeds the 3.5-percent tax, it must absorb the employee tax up to the amount of its current obligation.

The total income of an individual subject to tax from wages, self-employment income, and unearned income would be limited to $15,000 annually (or 125 percent of the earning base used in the social security program, whichever is higher). For persons age 60 and over, the first $3,000 of unearned income would not be taxable. For an employer, the entire payroll would be taxed. In addition to workers under social security, Federal, State, and local government employees would be subject to the tax, but State and local governments would not pay the employer tax. Members of the armed forces would not be taxed.

The funds of the program would be held in a health security trust fund with three accounts: (1) a health service account to pay benefit costs, (2) an account for administrative costs, and (3) a health resources development fund. The present hospital and medical insurance trust funds of Medicare would be transferred to the new trust fund.

Standards for Providers of Services

The standards for participation by providers of services would be similar to those of Medicare, but would also include others. (Medicare standards are shown on page 117). In addition, all providers must agree that (1) services would be furnished without discrimination on the basis of race, color, or national origin, (2) no charge would be made to the patient for covered services, and (3) required information and records would be supplied.

Hospitals

Standards for general hospitals are similar to those under Medicare, with two additional requirements. Hospitals cannot refuse to grant staff privileges on grounds other than professional qualifications, and they must have a pharmacy (and a committee to supervise drug therapy).

Skilled Nursing Homes

In addition to Medicare standards, nursing homes must be affiliated with a hospital or HMO whose medical staff assumes responsibility for professional services in the nursing home.

Home Health Agencies

Standards are similar to Medicare. Agencies would need to be public agencies or nonprofit organizations.

Health Maintenance Organizations

To qualify as a health maintenance organization, an organization would need to provide services to an enrolled population through group practice or similar approved arrangements. The organization would be required to furnish all covered health services, except mental health and dental services. Institutional services could be furnished by arrangements with other providers. Premiums or other charges for noncovered services must be reasonable. It must accept all persons in the area who wish to enroll. The organization must provide preventative services, assure continuity of care, and make services readily available to enrollees. It must have a committee which would establish medical standards and review utilization and quality of services. The organization would also need to meet the general requirements of the program concerning continuing education of professional personnel, and other requirements (to be established) concerning quality of care. It must employ paramedical personnel to the extent possible. The organization would have to be nonprofit.

Professional Foundation

A professional foundation sponsored by a State or local medical society could qualify as a provider of service. The foundation, which would be organized on a nonprofit basis, would be required to furnish the same covered services as the HMO and could also provide other types of covered and noncovered services. The foundation must permit all qualified physicians to participate (including those not members of the medical society). It would take responsibility for compensating professionals and other providers furnishing services on its behalf on a basis it prefers (including fee-for-service).

The foundation would need to meet requirements similar to those for HMO's (described above) regarding open enrollment for the public, reasonableness of charges for noncovered services, and requirements for continuing education and quality of care. (The requirement that services be provided through group practice or similar arrangements is not applicable to the foundations.) Similar arrangements could be made to establish dental society foundations.

Other Health Service Organizations

Other types of organizations, including public or nonprofit agencies which provide comprehensive health care services, but not necessarily to an enrolled population, could qualify as providers. Also, organizations (such as community health centers) could qualify to furnish

primary medical care and make arrangements to furnish and coordinate other medical services.

Professional Practitioners

Physicians, dentists, optometrists, and podiatrists licensed in a State before the start of the program would be eligible to participate, but would need to meet requirements for continuing education established by regulations. National standards for professionals would be established by regulation for those licensed after the program began. A State-licensed practitioner who met the national standards would be considered qualified in any other State. Major surgery and certain other specialist care could be furnished only by qualified specialists. Services of professional practitioners provided in a nonparticipating hospital would not be covered.

Other Providers

An independent laboratory or radiology service or a provider of drugs, medical appliances, or ambulance services, would need to meet requirements of State law and additional ones established by regulation.

Utilization Review

The requirements for utilization review in hospitals and skilled nursing homes include all those of Medicare. In addition, the hospital utilization committee would report its findings, on request, to the Health, Education, and Welfare regional office. For skilled nursing homes, utilization review would be conducted by a State or local public health agency, under contract with the Department, or by the regional office.

For specified types of surgery, prior consultation and approval by a qualified specialist would be required.

Independent physicians and dentists in general practice must maintain records and make reports, as required by regulations, for purposes of medical audit.

Scope of Services

Participating hospitals and other providers (except individual practitioners) could be directed by the Department to add or discontinue covered services, provide services in a new location, arrange for transfer of patients and medical records, and establish coordination or linkages with other providers. Such an order could be issued only on the recommendation of, or after consultation with, the State health planning agency and is subject to hearings, appeals, and judicial review.

Reimbursement of Providers of Services

National Health Budget

Each year, a national health budget for the coming year would be established. The budget would be based on the cost of the program in the current year adjusted for estimated changes in the Consumer Price Index, population, and the number and capacity of providers. Consideration would also be given to the extent to which costs are being controlled by improvements in delivery. However, the budget could not exceed the estimated total receipts for that year from taxes and general revenues.

The budget could be modified if later estimates of experience indicated that tax receipts or expenditures differed significantly from the estimates or if an epidemic or similar event required higher expenditures. A needed increase in a budget would be promptly reported to Congress.

Allocation of Funds

Funds would be allocated to each region on a per capita basis for institutions, physicians' services, dental services, drugs, appliances, and other professional and miscellaneous services. The amount for each category would be based on that spent during the past year modified for estimated changes in various factors (as described previously). The regional funds would be further allocated on a similar per capita basis to the health service areas. The bill provides authorization to eliminate unwarranted differences in average costs of health service among the regions by curtailing increases in funds to high expenditure regions and increasing the availability of services in low expenditure regions.

General Hospitals

Hospitals would receive a predetermined annual budget under regulations establishing the costs and services to be recognized in the budget. A uniform accounting system would be required. The compensation of professional practitioners (such as pathologists and radiologists) associated with the hospital would be included in the budget.

Psychiatric Hospitals

A psychiatric hospital rendering primarily active treatment to patients would be paid on the same basis as a general hospital. Those also providing noncovered services (such as custodial care) would be paid a predetermined rate per patient-day for the covered services.

Skilled Nursing Homes and Home Health Agencies

Payments would be based on an annual budget, as for general hospitals.

Health Maintenance Organizations and Professional Foundations

A HMO or professional foundation would receive a per capita amount for enrolled persons for ambulatory services they are required to provide, based on the per capita allocation for the various services in the local area.

If they also provide hospital or nursing home care in their own facilities, they would receive an annual budget amount for these services. If they arrange for hospital or skilled nursing home services through other providers, they would be reimbursed on the basis of an amount per patient-day for services used by their enrollees. The organization or foundation would be entitled to 75 percent of any savings resulting from its lower utilization of institutional services (whether furnished by the organization or through other providers) compared to that of a similar population group.

As an alternative, the payment for hospital and nursing home care would be based on a reasonable per capita payment per enrollee, in which case the organization or foundation would retain any savings resulting from lower than estimated use of these services.

Other Health Service Organizations

Other organizations such as health centers and State or local health agencies could be paid by any agreed method, other than fee-for-service. Independent pathology laboratories or radiology services could elect fee-for-service, approved budget, or any other agreed basis. Methods of payment for other types of providers would be specified in regulations.

Payment to Professional Practitioners

The major methods of payment available to physicians, dentists, and other professionals would be fee-for-service, capitation, and salary.

Fee-for-service would be generally available to all. The amount of fees would be determined by fee schedules or relative value scales, prescribed by regulation after consultation with representatives of the professions. The administration of fees could be delegated to a medical or professional society (or an agency selected by the society).

Capitation would be available only to independent physicians and dentists in general or family practice. An annual amount would be paid for each person enrolled to receive all services from the practitioner. These professionals could receive fee-for-service payments for services to persons not enrolled with them on a capitation basis.

By agreement with the local or regional office, a practitioner could be paid a full-time salary, or he could receive a part-time salary as a supplement to other methods of compensation. By agreement, specialists could also be paid per session or per case.

From the predetermined fund for physicians, dentists, and other professional services for an area (based on the per capita allocation for these types of services in the area), funds would be allocated to professionals selecting salary, capitation, and fee-for-service. If, during the year, total payments for fee-for-service were greater than estimated, the amount of fees would be reduced proportionately.

The law authorizes experimentation with other methods of reimbursement if they would not increase costs.

Delivery and Resources

Preparing for the Program

Financial assistance would be provided, before the start of the program, for the purpose of increasing health planning, alleviating shortages and maldistribution of facilities and manpower, and improving the organization and delivery of health services. The appropriations for this purpose would amount to $200 million and $400 million, respectively, for the 2 years before the program begins. In addition, Public Health Service funds for State comprehensive and areawide health planning would be increased to the extent necessary.

After the program starts, all expenditures for improvement in delivery and resources would come from the health resources development fund (except as noted below). This fund would receive, in the first year, 2 percent of the total income of the program and this allocation would be increased by 1 percent (at 2-year intervals) until it reached its ultimate rate of 5 percent.

Health Planning

The bill directs the Department of Health, Education, and Welfare to undertake planning to improve the supply and distribution of manpower and facilities and the organization of health services. State comprehensive health planning agencies (approved under the Public Health Service Act) would be given primary responsibility for coordinating the work of health planning groups within the State and interstate health planning agencies. The Department would assume these functions in States that do not carry out their responsibilities.

The bill states that priority is to be given to the provision of ambulatory services on a comprehensive basis, including the development

of HMO's and the strengthening of coordination and linkages among providers of services.

Health Maintenance Organizations

Grants could be made to a public agency or nonprofit organization for up to 90 percent of the expenses of planning and developing a new HMO. In addition, loans could be made for the construction costs of a new HMO, up to 90 percent of cost. Existing HMO's could receive similar development grants and construction loans, for expansion of their facilities, to a maximum of 80 percent of costs.

In addition, the operating deficit of newly established or enlarged HMO's could be paid as long as 5 years, if the system is making progress toward self-support.

Under the special improvement grants provision of the bill, HMO's could receive grants for the (1) purchase of diagnostic and therapeutic equipment; (2) purchase of equipment and other expenses for improving methods of utilization review, budgeting, and recordkeeping; and (3) costs involved in improving coordination and linkages of services.

The grants for improvement of coordination and linkages would also be available to all hospitals, nursing homes, and other providers of services outside the HMO's.

Manpower Training

The health security board, consulting with State planning agencies, would establish priorities for education and training of health manpower. Funds for this training would be provided by contracts with educational or other organizations, and allowances could also be paid directly to students. Funds may be provided for training or retraining, as follows:

(1) Training of medical students for general or family practice or for specialties in critical shortage.

(2) Training for professional and paramedical occupations, if other Federal financial assistance is not available. Priority would be given to those professionals who agree to work in shortage areas and in HMO's.

(3) Development of new kinds of health personnel, especially those useful in connection with HMO's. The new occupations could include teaching of personal health care, liaison with health care organizations, and consumer representatives. Under this provision, additional grants could be made to study the usefulness of the new occupations.

(4) For members of disadvantaged groups who are training for health occupations, special remedial education could be provided and additional allowances paid to the students.

Other Federal Assistance

Financial assistance under the program could not be used to replace funds available under other Federal programs and the Executive Branch of the Government is directed to use these funds to further the objectives of the national program. The health security program could loan 90 percent of the non-Federal share (the funds which the sponsor of a project ordinarily contributes) required under another government program. Where a loan has been obtained under another Federal program, the health security program could pay the interest on the loan that exceeds 3 percent.

Home Care

The bill provides authority to make grants for pilot projects of home maintenance care, including homemaker services, laundry services, meals-on-wheels, and assistance in transportation and shopping.

DINGELL BILL

The "National Health Insurance Act" was introduced by Representative John D. Dingell of Michigan as H.R. 33. It is similar to the Wagner-Murray-Dingell national health insurance proposal originally introduced in 1943.

General Concept and Approach

This proposal would establish a national health insurance program covering almost all residents of the United States. Standard benefits are broad and they would be financed through payroll taxes and Federal-State general revenues. The program would be administered by the Federal Government but would be decentralized with major administrative responsibilities placed at the State and local level. The bill contains provisions designed to improve the supply, quality, and distribution of health manpower and facilities.

Coverage of the Population

Virtually all U.S. residents would be covered. Almost all employees and self-employed persons would be covered and all persons eligible for social security benefits would be protected. Funds appropriated for various Federal-State health care programs could be used to obtain coverage for recipients of public assistance and the unemployed.

Benefit Structure

The proposal permits broad medical benefits but, in implementing the program, benefits would be made available in accordance with a State plan. The standard benefits available without limit, except as indicated, are as follows:

Institutional Services

General hospital inpatient care: 60 days.
Psychiatric and tuberculosis hospital care: 30 days; length of stay can be extended by regulation if funding and facilities are adequate.
Hospital outpatient care.

Personal Services

Physicians' services.
Dentists' services.
Physical checkups: periodic medical and dental examinations.
Home health services.
Podiatrists' services.
Optometrists' services and eyeglasses.
Laboratory and X-rays.
Physical therapy and related services.

Other Services and Supplies

Medical appliances.
Prescription drugs: types of drugs which are unusually expensive.

If the national health insurance board in consultation with the national advisory medical policy council (both created by this bill) finds that available resources are inadequate to provide dental, home health, or certain other specified services, it may limit these services for a period. In the case of dental services, priority would be given to children.

Administration

The program would be administered at three levels of government--Federal, State, and local--with the major operating responsibility falling to the State and local jurisdictions. Each State would evaluate its health resources and capabilities and, in accordance with national guidelines, would develop a health care plan. The State plans would be submitted to the national health insurance board and, when approved, the board would contract with the State for the administration of the program within that State.

Federal Level

A national health insurance board with five members would be established in the Department of Health, Education, and Welfare. Three members would be appointed by the President to serve with the Surgeon General and the Commissioner of Social Security. The board would establish the regulations and standards for the program, supervise the States and allocate funds. If the board finds that a State is not complying with the provisions of its plan, the board can administer the program in that State.

A national advisory medical policy council would be established, consisting of the chairman of the national board and 16 members appointed by the Secretary of Health, Education, and Welfare. At least eight

members would serve as consumer representatives and at least six as representatives of providers of medical services. The advisory council would advise the board on matters of general policy and administration, establishment of professional standards, and other matters.

State and Local Levels

The administrative agency in each State would, if possible, be the same agency that administers its public health or maternal and child health programs. State plans would:

(1) provide for a State advisory committee with a majority of members representing consumers and the remaining members representing providers;

(2) establish local health-service areas and provide methods for selecting their advisory committees;

(3) provide for surveys of resources and needs of the State;

(4) give assurance that maximum use would be made of available health personnel and facilities and that funds would be allocated to local areas in such a way as to correct maldistributions and inadequacies.

Local area agencies, with the assistance of a similar advisory council representing consumers and providers, would administer the program at the local level, make payment to providers, and carry out related administrative duties.

Relationship to Other Government Programs

Initially, aged persons could receive those benefits of the program not provided under Medicare. The Department of Health, Education, and Welfare would be required to study the relationship between the national health insurance plan and the Medicare program and devise methods of incorporating Medicare into the national plan. Funds appropriated for Medicaid and other Federal-State assistance programs could be used by States to finance the cost of covering needy persons who do not make regular contributions required by the program.

Financing

A personal health service account would be established to hold the funds of the national program. The account would receive an amount equal to 3 percent of total earnings. (The definition of earnings would be the same as under the social security law.) In addition, for the specific purpose of financing the cost of dental, home health, and certain other services, the account would receive an additional amount

equal to one-half of 1 percent in the first year of the program. This additional amount would increase to an ultimate rate of 1 percent in the third year. Further, in the first year of the program, an additional 1 percent of earnings would be appropriated as a reserve and the bill authorizes any additional funds required to meet expenditures. While the bill does not specify the source of any of these funds, the apparent intent is that they be obtained from a payroll tax on employers and employees covered under social security.

Standards for Providers of Services

Standards of participation for providers of services under the program would include the following:

Hospitals and Institutions

Hospitals or institutions qualified under State standards could participate in the program. If a State has not established standards, the national board would establish them for the State.

Professional Practitioners

Physicians, dentists, and podiatrists legally authorized to practice in a State would qualify. Specialists would be required to meet standards established by regulation.

Nurses

Professional nurses registered in the State would qualify. Practical nurses qualified under State standards or standards established by regulation could provide home health services.

Reimbursement of Providers of Services

The national board would allocate funds among the States for each of five classes of health services (medical, dental, hospital, home health, and auxiliary) on the basis of population, availability of health resources and the costs of services, as indicated in the State plan. The allocation would be designed to assure that adequate health benefits are provided in all States and to improve the adequacy of services where they are below the national average.

The State agencies would contract with providers of care for services under the program and determine rates of payments. The payments could be administered by the State agency or the local health-service area. Nonprofit health-service insurance plans could be used as agents or intermediaries.

Hospitals and Other Institutions

Hospitals and other institutions would be reimbursed on the basis of reasonable costs. In calculating costs, the payment for room and board would be based on the least expensive multiple-bed accommodations. A maximum rate for hospitalization could be established (after consultation with representatives of provider organizations) and it could vary according to locality and class of service.

Professional Practitioners

Physicians and dentists could select reimbursement under various methods, including fee-for-service (based on a fee schedule), capitation (with maximum limits on the number of registered patients), full- or part-time salary, or a combination of these methods. Specialists could choose the same methods and, in addition, payment on a per session or per case basis.

Rates of payment would be geared to local conditions. In deriving the rates of payment under the various methods, consideration would be given to the annual income that would accrue to practitioners. Further, reimbursement would be designed to provide incentives to practitioners to advance in their professions, pursue postgraduate studies, maintain high-quality service, allow for adequate vacation, and practice in areas where their services are needed.

Home Health and Other Services

Methods of payment for home health and other services would be determined by the State agency administering the program.

Delivery and Resources

The national health insurance board, after consultation with the national advisory council and other Federal agencies, is authorized to make grants-in-aid for training and education to students and educational institutions. To finance this program, $10 million would be available for the first year of the program, $15 million for the second, and for each following year an amount equal to one-half of 1 percent of benefit expenditures in the previous year.

FULTON-BROYHILL--HARTKE BILL

The "Health Care Insurance Act of 1973" was introduced by Representatives Richard H. Fulton of Tennessee and Joel T. Broyhill of Virginia as H.R. 2222 and by Senator Vance Hartke of Indiana as S. 444. The bill, referred to as the Medicredit proposal, is endorsed by the American Medical Association.

General Concept and Approach

The Medicredit proposal would provide tax credits against individual income taxes to offset, in whole or in part, the premium cost of qualified private health insurance policies. A qualified policy must provide specified basic and catastrophic benefits and the maximum amount of the tax credit would be based on the premium cost of this policy. The amount of the credit for a family would be graduated on the basis of the family's income tax liability (the amount of tax payable for the year) with the larger credits available to lower income groups. Families with little or no tax liability would receive a payment voucher for purchase of the insurance. All persons could voluntarily elect coverage under the plan, except those age 65 and over.

Coverage of the Population

Since all families and individuals potentially subject to the Federal individual income tax would be eligible, virtually the entire population could voluntarily elect coverage under the plan. However, persons age 65 and over (who would remain under the Medicare program) would not be covered by the proposal.

Benefit Structure

The amount of the tax credit would be based on the premium cost of a qualified policy which provides specified basic and catastrophic benefits. For the catastrophic benefits, the amount of tax credit would be equal to the full premium cost applicable to those benefits. For the basic benefits (which constitute the major part of the benefit package) the amount of the credit would be equal to the premium for persons with no tax liability, and would be slowly graduated downward (for each $10 increase in tax liability) with a credit of 10 percent available to those with taxes of $891 or more.

This schedule of credits is applicable to all types of returns including individual returns and joint returns of married couples. In computing the amount of tax liability for Medicredit purposes, the taxes

of dependents would be included (even though the dependent files an individual return). Also, the tax liability of a husband and wife filing separate returns would be combined.

The following tabulation shows the percentage of the premium cost of the basic benefits that could be taken as a credit at selected levels of tax liability, as shown in the Medicredit bill. Also a column has been added showing the equivalent adjusted gross income, for a family of four taking the standard deduction, at specified tax liability levels (for 1973 when the Tax Reform Act of 1969 became fully effective).

Amount of tax liability	Amount of adjusted gross income	Amount of tax credit (percent)
None	$4,300 or less	100
$100	$5,000	90
$300	$6,350	70
$500	$7,600	50
$700	$8,750	30
$891	$9,950 or more	10

Individuals or families with no tax liability would receive a voucher certificate which would be accepted by a carrier for the purchase of a qualified insurance policy. Those with a tax liability less than the amount of the credit could receive a certificate, or claim the additional credit like an overpayment of taxes.

Taxpayers who elect a tax credit could not claim the health insurance premium as a medical expense deduction for income tax purposes.

Employer-Employee Plans

Under present law, an employer may take the full cost of his premium contributions for health insurance for his employees as a business deduction. Under the proposal, he must maintain a qualified plan (providing the specified benefits) to continue to take a full deduction; otherwise, only one-half the contributions could be taken.

The employee, in computing the amount of premiums against which he may take a tax credit on his personal tax return, would count 80 percent of the employer contribution to a qualified plan as if it were his own contribution.

Qualified Insurance Policy

As indicated, a qualified policy under the plan would offer specified basic benefits and catastrophic benefits. The policy would need to be

guaranteed renewable and benefits could not be refused because of pre-existing medical conditions. The benefits of the policy are shown in table 1. (See page 95.)

General dental care would initially be limited to children age 2-6 and would be extended each year to children 1 year older, up to age 17. (For example, in second year to age 7, in third to age 8.) Emergency dental services and certain oral surgery (similar to the Medicare oral surgery benefit) would be provided at the start of the program without age limitations. The physicians and outpatient service benefits include unlimited physical examinations, innoculations, well-baby care, and psychiatric care.

The family's total payment for coinsurance under the basic coverage for physicians', laboratory, and X-ray services combined would be limited to $100 annually (20 percent of the first $500). An additional limit of $100 annually would apply to hospital outpatient, home health and ambulance services combined, and a separate $100 limit for dental care.

Benefits under the catastrophic coverage (which applies to additional hospital days, prosthetics and blood) would first become payable after a corridor deductible (out-of-pocket payment) which would vary according to family income. Cost sharing payments made under the basic plan would be creditable toward meeting this corridor deductible. The deductible, which would be based on the family's taxable income (after exemptions and deductions) including the income of dependents, would be equal to 10 percent of taxable income.

Administration

Persons would purchase qualified health insurance from private health insurance carriers who would issue policies, collect premiums (or vouchers), and process claims for benefits.

State insurance departments would determine whether insurance carriers and policies are qualified under the Medicredit program. Carriers would be required to participate in assigned-risk pools and accept the poor risks assigned them by the State insurance departments.

The Department of Health, Education, and Welfare would issue and redeem the health insurance voucher certificates. Also at the national level, a health insurance advisory board would be established, consisting of the Secretary of Health, Education, and Welfare (chairman), the Commissioner of Internal Revenue, and nine additional members (the majority of whom would be physicians) appointed by the President with Senate approval. The board would establish the regulations for the administration of the program and issue the Federal standards to be

used by the State insurance departments in determining whether insurance carriers and policies are qualified. In consultation with carriers, providers, and consumers, it would study methods to maintain the quality of care and the effective use of resources through utilization and peer review.

Relationship to Other Government Programs

The bill provides that benefits claimed under Medicredit may not be duplicated under other programs financed by the Federal Government. The Medicredit proposal would affect the Medicaid and other assistance programs by covering those services for the low-income population that were provided by the assistance programs.

Financing

The Medicredit program would be financed from Federal general revenues. The granting of tax credits would result in a reduction in Federal income tax receipts and the voucher certificates would be redeemed from general revenues through a special trust fund created for this purpose.

Standards and Reimbursement of Providers of Services

The bill includes a clause which prohibits Federal supervision and control over the practice of medicine, the manner in which services are provided, the selection or compensation of providers of services, or the operations of providers of services.

The insurance carriers participating in the program would reimburse the providers of services. The bill requires that payment for services under the program must be on the basis of usual and customary charges.

Delivery and Resources

There are no specific provisions regarding these subjects.

TABLE 1.--FULTON-BROYHILL--HARTKE BILL: Benefit provisions under a qualified insurance policy 1/

Type of service	Basic benefits	Catastrophic benefits 2/
Institutional services:		
Hospital inpatient care.	60 days a year with a $50 deductible for each stay.3/	Unlimited additional hospital days.
Skilled nursing.....	2 days in a skilled nursing facility may be substituted for 1 day of hospital care, with a $50 deductible for each stay.	30 additional days.
Personal services:		
Physicians' services ..	No limit. (20% coinsurance, with a limit per family of $100 a year.)	4/
Laboratory and X-ray		
Hospital outpatient care	No limit. (20% coinsurance, with a limit per family of $100 a year.)	4/
Home health services....		
Ambulance service.....		4/
Dental services.....	As specified.5/ (20% coinsurance, with a limit per family of $100 a year.)	
Other services and supplies:		
Medical appliances.....	---	Prosthetic devices.
Blood.....	---	Outpatient blood and plasma (after the first 3 pints.)

1/ For persons on Federal cash assistance, any deductibles and coinsurance would be met by the State under Medicaid.

2/ Payable after family meets a secondary deductible of 10% of the family's taxable income reduced by the amount of copayments made by that family for covered basic benefits.

3/ Includes inpatient blood and plasma (after the first 3 pints).

4/ Services are provided under basic coverage without limit.

5/ General dental care for children; emergency dental care and oral surgery for all persons (see text).

ASHBROOK BILL

The "Health Care Insurance Act of 1973" was introduced by Representative John M. Ashbrook of Ohio as H.R. 288. It is identical to H.R. 4960 introduced by Representatives Richard H. Fulton and Joel T. Broyhill in the 92d Congress. Representatives Fulton and Broyhill have introduced a revised bill, H.R. 2222, supported by the American Medical Association, discussed previously.

The major revision in the current Fulton-Broyhill bill (which distinguishes it from the old Fulton-Broyhill bill and the current Ashbrook bill) are as follows:

(1) Additional medical services are added to the basic benefits including home health care and certain dental care services, all subject to a 20-percent coinsurance. Routine dental care would initially be limited to children age 2-6 and would be extended each year to children 1 year older, up to age 17. Emergency dental services and certain oral surgery (similar to the Medicare oral surgery benefit) would be provided at the start of the program without age limitations.

(2) Total coinsurance payments by the family would be limited to $100 annually (20 percent of the first $500 of expenses) for hospital outpatient, home health and ambulance services combined, and a separate similar $100 limit would apply to dental care. (The separate limitation of $100 for physicians, laboratory and X-ray has been retained.)

(3) The formula for determining the "corridor deductible" after which catastrophic benefits become payable would be based on 10 percent of the family's taxable income. The previous formula was based on varying percentages applicable to specified income intervals.

ROE-BEALL BILL

The "National Catastrophic Illness Protection Act of 1973" was introduced by Representative Robert A. Roe of New Jersey as H.R. 1054 and Senator J. Glenn Beall, Jr. of Maryland as S. 587. It is identical to a bill introduced first in the 92d Congress by Representative Lawrence J. Hogan of Maryland.

General Concept and Approach

The proposal would establish a program of private health insurance protection against the cost of catastrophic illness. Persons could voluntarily buy private insurance policies that would pay for medical expenses which exceed a specified amount, with the amount depending on family income and size. The program would be administered by private insurance carriers under State supervision. The premium would be paid by the policyholder, but the Federal Government could subsidize the premium, using funds from general revenues. The Federal Government would also administer a reinsurance plan for insurance carriers under the plan.

Coverage of the Population

All persons could obtain coverage on a voluntary basis.

Benefit Structure

For the purpose of this program, any services defined as medical care under the present Federal income tax law relating to medical expense deductions could be included in a State plan.

The policies would pay the medical expenses of individuals and families whose expenses exceed a specified amount (referred to as the annual deductible). This deductible would vary according to family income and number of dependents. For low-income people no annual deductible would be applicable (and thus the plan would pay for all covered medical expenses) but the deductible would rise rapidly as family income increased.

The amount of the deductible would be based on the family's "adjusted income," which is the "adjusted gross income" shown on the Federal income tax return reduced by the total amount of personal exemptions. In calculating the deductible, the first $1,000 of "adjusted income" would be disregarded and the deductible would be equal to (1) 50 percent of adjusted income between $1,000

and $2,000, plus (2) 100 percent of adjusted income over $2,000. An illustrative schedule based on this formula for a family of four appears below:

Adjusted gross income	Adjusted income 1/	Annual deductible
$1,000.....	None	None
$4,000.....	$1,000	None
$5,000.....	2,000	$500
$7,500.....	4,500	3,000
$10,000.....	7,000	5,500
$20,000.....	17,000	15,500
$30,000.....	27,000	25,500

1/ Based on personal exemption of $750 per person, which would become effective for 1973 returns.

In figuring the family's medical expenses, medical costs paid in a year for continuous, uninterrupted care which began in an earlier year would be considered to have been paid in the earlier year.

All medical expenses incurred would count toward meeting the deductible including expenses paid by other private insurance or covered by Medicare, Medicaid, or other public programs.

Administration

Each State would design its own health insurance plan under regulations of the Department of Health, Education, and Welfare. The State insurance department would make arrangements with, and supervise, private health insurance carriers who would sell the insurance, collect premiums, and administer claims.

A carrier organization would be established in each State that would attempt to distribute the risks equitably among the insurers and would obtain coverage, through assigned risk pools, for persons unable to obtain coverage at the regular premium rate.

The Department of Health, Education, and Welfare could administer a plan in any State that has not established one.

Relationship to Other Government Programs

Medicaid and other assistance programs would be affected because they would not make payment for the services covered by the insurance. Most other Government programs would not be affected.

Financing

Periodically, the Department of Health, Education, and Welfare would determine the actuarial value, according to family size and composition, of the catastrophic insurance policy in each State. The Department would then establish a premium rate which could be lower than the actuarial value, if the Department believed that a lower rate was desirable in order to obtain more widespread coverage. The Federal Government would pay the insurance carrier the difference between the actuarial value and the established premium. These payments, referred to as premium equalization payments, would be paid from Federal general revenues through a national catastrophic illness fund.

The Department would also arrange for reinsurance for carriers who have incurred extraordinary losses in connection with the catastrophic insurance. The premiums for this reinsurance would be paid by participating carriers as determined by the Department. This reinsurance plan would also be administered through the national catastrophic illness fund and the Department could contract with private firms to handle the reinsurance claims.

Other

There are no provisions in the bill concerning standards for providers of service, reimbursement of providers, or health care delivery and resources.

SAYLOR BILL

The "National Health Care Program" was introduced by Representative John P. Saylor of Pennsylvania as H.R. 1916.

General Concept and Approach

The proposal would establish a two-part national health insurance program called the "National Health Care Program" and abolish the Medicaid program. All persons would be covered under one of the parts, depending on their annual income.

Part A of the proposal would provide the poor with basic coverage under private health insurance plans, as well as coverage of catastrophic health care costs. The program would be administered by the States, and financing would come from Federal and State general revenues.

Part B, a federally administered program, would insure the remaining population against catastrophic health care costs beyond a specified amount. It would be financed by a tax on wages, self-employment income, and other income of individuals.

PROVISIONS FOR THE MEDICALLY INDIGENT (PART A)

Coverage of the Population

All persons at or below a State level of medical indigence would be covered under this plan. Each State would determine the level of medical indigence for its residents, i.e., the level of income below which an individual or family cannot meet their normal health care costs.

Benefit Structure

The State would purchase a qualified private health insurance policy for eligible individuals and families. The bill does not specify the benefits that a qualified policy must include, but permits the inclusion, at the option of the State, of any services defined as medical care under the present income tax laws relating to medical expense deductions. (This definition encompasses a very broad range of health care services.) The value of the policy would be at least equal to the average annual cost of adequate health care

in that State. The State is also required to provide catastrophic coverage of all costs for health care beyond the limits of the basic insurance policy. There would be no cost sharing.

Administration

The program would be administered by the States under agreement with the Department of Health, Education, and Welfare. If a State refuses to enter into an agreement, or fails to comply with requirements of an agreement, the Federal Government would administer the program in the State. In either case, the health benefits plans would be operated and administered by private insurance carriers.

Relationship to Other Government Programs

The proposal would replace the current Medicaid program. No specific reference is made to other Government health programs, but the bill calls for a report on provisions of law which require modification or repeal.

Financing

The program would be financed by State and Federal revenues. The Federal Government would pay States 85 percent of the cost of premiums for the purchase of the basic insurance coverage. States would pay the balance of the cost of basic coverage and the entire cost of coverage for the catastrophic program.

If a State does not participate in the program, the Federal Government would pay the entire cost of both types of coverage, and would recover those amounts (that the States would otherwise have been required to pay) by withholding Federal funds otherwise payable to the States.

Delivery and Resources

There are no provisions directly affecting the organization and delivery of medical services.

CATASTROPHIC HEALTH INSURANCE FOR NON-INDIGENTS (PART B)

Coverage of the Population

All persons with incomes above the State-determined level of medical indigency would be eligible for coverage under this part.

Benefit Structure

A program of catastrophic health insurance would be established that would cover 90 percent of health care costs above a specified annual deductible. As for the plan for the medically indigent, benefits could include any services defined as medical care under the present income tax laws.

The deductible amount that would have to be met before payment could begin (which could include expenses that were already paid under private insurance or public programs) would consist of the larger of the following:

$5,000 for all persons or families under age 65, or
$1,000 for persons aged 65 or over, or
25 percent of individual or family gross income for the year.

Administration

The catastrophic program would be administered by the Department of Health, Education, and Welfare and would follow, to the extent possible, the same procedures and requirements used under Medicare.

Relationship to Other Government Programs

The bill calls for a report, as discussed above.

Financing

The plan would be financed by a special tax of 0.4 percent on the sum of an individual's wages, self-employment income, and other earned or unearned income over $2,000, up to the same maximum as under the social security law. Revenues would be placed in a Federal health care trust fund, managed by a board of trustees, from which all benefits and expenses would be paid.

Other

The bill provides that, to the extent feasible, the reimbursement standards and procedures under Medicare be utilized for the catastrophic health insurance program (Part B). The bill does not include specific provisions regarding the organization and delivery of health services.

LONG-RIBICOFF BILL

The "Catastrophic Health Insurance and Medical Assistant Reform Act" was introduced by Senators Russell B. Long of Louisiana and Abraham A. Ribicoff of Connecticut as S. 2513.

General Concept and Approach

The proposal is presented in three major parts. A catastrophic illness insurance plan would provide benefits for persons in the general population who have incurred unusually large hospital or medical expenses. The medical assistance plan would, in effect, provide basic and catastrophic benefits for low-income persons through a uniform national plan. These two plans would be administered through the mechanism of the present Medicare program and are designed to coordinate their benefits and other provisions.

The proposal also includes provisions for encouragement and certification of improved private health insurance, also coordinated with the two health plans.

CATASTROPHIC ILLNESS INSURANCE PROGRAM

The catastrophic plan, which would cover persons and their dependents insured or receiving benefits under social security, would provide catastrophic benefits to persons who have already incurred long hospital stays or large medical bills. The program would be administered through the Medicare program and financed by special payroll taxes.

Coverage of the Population

Persons who are fully or currently insured under the social security program 1/ or entitled to social security benefits would be eligible, as well as their spouses and dependent children. In addition, eligibility would be extended to additional persons (and their dependents) who have certain specified credits under social security, but not enough to meet the regular insured requirements.

1/ A person who has social security credit for at least 1-1/2 years of work within a 3-year period is currently insured. To be fully insured, a person needs at least 1 quarter of coverage for each calendar year elapsing after 1950 or, if later, after the year in which he attained age 21, up to the year he becomes entitled to benefits. A person who has 10 years of work is fully insured for life.

State and local governments would have an option to "buy" into the program and cover, as a group, all their employees and annuitants (if not covered by social security) under an agreement with the Federal Government. The State would reimburse the program for the cost of benefits and related administrative expenses for these persons. The regular payroll tax for catastrophic illness benefits (described later) would not apply to State and local government employment.

Benefit Structure

The catastrophic health insurance program would cover the same kinds of benefits as provided under the Medicare program, as follows:

Institutional Services

Hospital services.
Skilled nursing facility services.

Personal Services

Physicians' services.
Laboratory and X-ray services.
Home health services.
Outpatient physical therapy services.

Other Services and Supplies

Medical supplies and appliances.
Ambulance services.

Hospital Inpatient Care and Skilled Nursing Care

Hospital inpatient care would be covered after the first 60 days of hospitalization during a year. Payment would begin with the 61st day of hospitalization, with no limit on the number of additional days. Days spent in a hospital in the last 3 months of a year (that are not covered days for that year) would be counted toward meeting the 60-day hospital deductible for the next year. As under the Medicare program, there would continue to be a lifetime limit of 190 days of care in psychiatric hospitals. Payment would be subject to the regular Medicare coinsurance rate.2/

2/ The coinsurance rate under the proposal is related to the Medicare inpatient hospital deductible which, effective January 1973, was $72. For hospital care, the coinsurance is one-quarter of the Medicare deductible ($18) per day and for skilled nursing care, one-eighth ($9). The amount of the Medicare deductible is changed in January of each year if the average per diem rate for inpatient hospital services rises.

For persons under Medicare, hospital stays covered both under the proposal and under the Medicare program--which provide 90 days in a spell of illness and an additional 60-day lifetime reserve--would be reimbursed under the catastrophic program.

Skilled nursing facility services following a hospital stay would be covered for 100 days in a spell of illness. Payment would be made only after the individual had met the 60-day hospital deductible and was covered for at least 1 hospital day under the catastrophic program. Payment would be subject to coinsurance of the same amount as under Medicare.3/

Physicians' services and the other types of personal and other medical services, described above, would be covered without limit (except that the Medicare limitation of $250 in a year on payment for outpatient psychiatric physicians' services in a year would be retained). Payment would be made after a family has incurred expenses of $2,000 in the year, referred to as the "medical deductible." Only expenses for these covered types of medical services would be counted toward the deductible. Medical expenses incurred in the last 3 months of the year (not covered for that year) would be counted toward meeting the deductible for the next year. Expenses covered under private or government health plans would count toward the $2,000 expense limit. Payment would be subject to 20-percent coinsurance, as under Medicare. (The medical deductible would have to be met separately from the hospital deductible.)

The $2,000 medical deductible would be adjusted each year, based on the physicians' fee component of the Consumer Price Index.

Total coinsurance payments for a person for all the hospital and medical services covered under the proposal would be limited to $1,000 in a year for an individual. After that, there would be no further payment by the patient.

Relationship to Other Government Programs

Since the program is based on the requirements and provisions of the Medicare law, its relationship to other Government programs would be essentially the same as the Medicare program. (See discussion of the Javits bill.)

Financing

The program would be financed, in a manner similar to Medicare, by a tax on wages and self-employment income now subject to social security taxes. The tax rates for employers, employees, and the self-employed would be 0.30 percent for the first 3 years of the program, 0.35 percent for the next 5 years, and 0.40 percent thereafter. A separate

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3/ *Ibid.*

catastrophic health insurance trust fund would be established to handle program receipts and expenditures.

Also, for the first 3 years of operation, appropriations to the trust fund would be authorized from Federal general revenues to provide an operating fund and a contingency reserve. The amount of these appropriations would be equal to one-half the estimated expenditures of the program for each of the 3 years. These appropriations would be repayable to the Treasury without interest.

MEDICAL ASSISTANCE PLAN FOR LOW-INCOME PEOPLE

The medical assistance plan is a plan for low-income and medically indigent persons. It would be administered through the Medicare program, but would provide broader benefits. It is designed to mesh with the catastrophic plan, as well as other public and private health plans. The proposal would be financed jointly from Federal and State general revenues.

Coverage

The benefits of the program would be available to citizens (and aliens admitted for permanent residence) whose annual family income is below the amounts specified below, without regard to their age, family status, employment, or State of residence.

Individual.....	$2,400
Family of two.....	3,600
Family of three.....	4,200
Family of four.....	4,800
Family of more than four.....	4,800 plus $400 for each additional member

The types of income counted for eligibility would include both earned and unearned income--including wages, self-employment income, support and maintenance, annuities, pensions, veterans payments, workmen's compensation, social security, and unemployment insurance. Also included are rents, dividends, alimony, inheritances, and life insurance payments exceeding $1,500. Excluded from consideration are small gifts and certain funds received for educational purposes (such as scholarships, loans, and fellowships).

By regulation, procedures may be established under which specified gross amounts of income from a trade, business, or farming may be considered sufficiently large to disqualify families even though their income technically falls within the limits. These procedures could be

similar to those under the present Supplemental Security Income (SSI) program for the aged, blind, and disabled.

In addition, families who meet all the requirements for eligibility under a State Medicaid program at the time the assistance plan started would automatically be eligible under the plan (assuming they met the citizenship or resident requirements) if their income was within 105 percent of the States' income requirements for Medicaid.

Spend-Down Provisions

Families with income higher than the specified amounts could still qualify for benefits under the "spend-down provision." Under this provision, the family's income for the purpose of eligibility is considered its actual income reduced by the amount of incurred medical expenses the family is legally obligated to pay out-of-pocket. (Thus a family of four with annual income of $5,000 would qualify after they incurred out-of-pocket medical expenses of $200.) These medical expenses could be expenses actually paid or the reasonable charge for the services, if not yet paid. The types of medical expenses considered for computing the spend-down include a broad range of services (such as dental care, prescribed drugs, and optometrist services) not included among the proposals' benefits. Eligibility under the spend-down provision may be determined on a prospective basis if the future income is determinable and a family member can be expected to need institutional care.

Determining Eligibility

Ordinarily, eligibility would be determined by the annual income for the past year, unless the amount of prospective income for the coming year would apparently be much greater or lesser than the past year's income. Eligibility would continue throughout the year unless the income increases more than 20 percent above the eligibility requirements. Provisions are also included to permit eligibility (and termination) during the year for families whose circumstances change.

Benefits

The benefits of the program, listed below, include all services under Medicare, but also several additional ones. There are no limitations on the amount of services or any cost sharing required, except as indicated.

Institutional Services

Inpatient hospital services: 60 days in benefit period.
Skilled nursing facilities.
Intermediate care facilities.

Personal Services

Physicians' services: $3 copayment for each of first 10 outpatient visits per family.
Laboratory and X-ray.
Home health services.
Prenatal and well-baby care.
Family planning, counseling, and supplies.
Periodic examinations: For children under age 18.
Outpatient physical therapy.
Immunizations and pap smears: By regulation.4/

Other Services and Supplies

Medical supplies and appliances.
Ambulance services.

Services in an intermediate care facility would be available to patients who do not require services in a hospital or skilled nursing facility, but who have a physical or mental condition which requires care (in addition to room and board) available only through institutional facilities.

Mental health care services provided in an accredited institution are included in the hospital inpatient benefit if the service constitutes active care and treatment. Mental care is also covered on an outpatient basis and the amount of these services is not limited if provided by an approved community mental health center. If provided otherwise (e.g., by a psychiatrist), it is limited to a maximum of 5 visits, but additional visits would be covered if approved by a professional review organization as being necessary to avoid institutional care or serious dysfunction. The outpatient mental health benefit also includes drugs (other drugs are not covered under the proposal) if the physician determines they are necessary to avoid institutional care. The covered drugs are only those included on a list which indicates the mental condition for which it is effective and the appropriate dosage.

Payment for Other Programs

Payment under the assistance plan would also be made on behalf of eligible persons in conjunction with the catastrophic program and the Medicare program, as follows:

4/ The bill also amends the Medicare law to add immunizations and pap smears to that program.

(a) payment of the coinsurance required under the catastrophic proposal,

(b) payment of full cost of benefits under the catastrophic proposal for persons not eligible under it, and

(c) payment of the supplementary health insurance (Part B) premium under Medicare.

Copayments

The $3 copayment requirement would apply to persons under the Medicare program only to the extent this amount is less than the regular cost sharing required under Medicare.

A special copayment requirement would also apply to individuals who are not a member of a family, after the 60th continuous day spent in a long-term facility. The amount of this copayment would be equal to the amount of the patient's monthly income, less $50. (A similar requirement would apply in a situation where all members of a family have a stay exceeding 60 days.)

Relationship to Other Government and Private Programs

The present Medicaid program would be abolished and replaced by the new program. The Medicare program would continue.

Payments under the proposal would, except where previously indicated, be secondary to all other government and private health care programs and plans. (It would be primary only where a State has established a program, with higher income limits than the proposal, designed to supplement it.) Thus, where a person has coverage under another public or private plan, the medical assistance plan would pay only for benefits (or any cost sharing) not covered by the other plan.

The bill states its intent that the proposal not be construed to preclude States from providing protection against health costs, or individuals from obtaining private health cost protection. Under penalty of law, the bill prohibits employers, who provide group health insurance for their employees, to exclude an employee because he is potentially eligible for benefits under the medical assistance proposal.

In the event a person was eligible for enrollment in a health insurance plan (for example, an employment-related group plan) under which the enrollees' contribution was 25 percent or less of the total premium, but did not enroll, benefits payable under the medical assistance plan would be reduced by $250 in a benefit period. A similar reduction would apply to aged persons who fail to enroll in the supplementary medical insurance (SMI) part of Medicare.

Financing

The program would be financed by Federal and State general revenues. The State share would be as follows: an amount equal to the State's present payments under the Medicaid program (1) for those types of services covered under the medical assistance proposal and (2) again, for services under the new medical assistance proposal, one-half the payments it would have made under Medicaid if its eligibility requirements were the same as the medical assistance requirements--which of course would be applicable only to States with less liberal requirements. (The State's contributions, based on its expenditures in the year before the new program began, would be a fixed amount and would not rise in future years.) The State's contribution would be reduced, however, by one-half its actual expenditures for types of services not covered by the proposal (but presently eligible for Federal grants under Medicaid).

The balance of the cost of the proposed program would be financed from Federal general revenues. All funds would be held in a special medical coverage trust fund.

PROVISIONS AFFECTING BOTH PLANS

Administration

Both programs would be administered through the administrative mechanisms of the Medicare program. Under Medicare, the Social Security Administration in the Department of Health, Education, and Welfare is responsible for general administration of the program. Private carriers under agreement with SSA act as fiscal intermediaries responsible for administration of claims and payments to providers of services. The bill includes a provision, relating to the medical assistance program, authorizing the consolidation of the activities of these carriers in areas with small populations if necessary to improve quality and efficiency.

As under Medicare, State agencies would be responsible for determining whether providers of services meet the conditions for participation under the two proposed programs.

Persons eligible under the proposed medical assistance could enroll in a health maintenance organization and receive their services from these organizations, on a basis similar to that authorized for Medicare beneficiaries under P.L. 92-603 (H.R. 1).

Standards for Providers of Service

The program would apply the same standards for providers of services as under the Medicare program. (See page 117.) For intermediate care

facilities (which are not covered under Medicare) the bill requires the facility to be licensed under State law and meet regulations (to be established) concerning proper provision of care and safety and sanitation; it specifically includes qualified Christian Science sanatoria and institutions on Indian reservations.

Reimbursement of Providers of Services

Providers of services under the catastrophic program would be reimbursed on the same basis as under the Medicare program. Under Medicare, hospitals, skilled nursing facilities, and home health agencies are reimbursed on the basis of the reasonable cost of services. Payments to physicians (and certain other providers) are determined on the basis of reasonable charges. In general, physicians may file and accept the Medicare payment as full payment (taking assignment). Alternatively, they may bill the patient, who files and receives the Medicare reasonable charge (which may be less, but not more, than the physicians' charge).

The bill specifies that for the medical assistance program the physician and other providers must accept the reasonable charge as full payment for services. This would also apply where the medical assistance payment is made to supplement a payment under another public or private insurance program. In this case, the reasonable charge for these services, as determined under the medical assistance plan, would be considered the full charge.

Of course, reimbursement under the catastrophic and medical assistance programs would be subject to the additional provisions relating to reimbursement under Medicare included in P.L. 92-603 (H.R. 1). This would include, for example, the limits on costs for institutional services recognized as reasonable ("cost ceilings"), limitations on payment for services in connection with disapproved capital expenditures, and limitations on payment where cost for an institution is less than its customary charges. The new limitations on increases in the amount of physicians' fees would also apply. It would of course also incorporate the health maintenance organization (HMO) provisions of H.R. 1 and the Professional Standards Review Organizations (PSRO) established to review the use and quality of services under Medicare and other programs under the social security law.

PRIVATE BASIC HEALTH INSURANCE CERTIFICATION

The purpose of this section is to encourage the availability of adequate and reasonably priced private health insurance policies. It would also facilitate the offering of these policies by pools of private carriers.

Certification

Private health insurance carriers would voluntarily submit health insurance policies to the Department of Health, Education, and Welfare for consideration as a certified policy. The policy must meet certain minimum requirements concerning coverage, benefits, and premium charges. Procedures are established for continuing review of these requirements and for reports by the carriers.

If a group health insurance policy is certified, the carrier must also make available, in the same geographic area, an equivalent nongroup (individual) policy.5/

The Department would designate an emblem indicating a policy has been certified. This emblem and other indications of certification could be used in advertising a policy to the public. Also, a carrier who offers certified insurance, and does so in each geographical area where it normally offers health insurance, would be given the status of an approved carrier. Beginning 3 years after the start of the program, only approved carriers could qualify as intermediaries or carriers under the Medicare program or the proposed medical assistance program.

Benefits

A certified policy must offer the following minimum benefits:

(a) Hospital inpatient benefits for at least 60 days of care, with a maximum deductible of $100, but with no further cost sharing.

(b) Medical coverage providing physicians' services in home, office, and institutional settings, providing coverage of at least the first $2,000 of medical expenses per person per year. The maximum deductible allowable would be $100 for a year (with credit given for expenses incurred in the last 3 months of the preceding year). Additional cost sharing is permitted, but the total of all cost sharing (deductibles, coinsurance, and copayments) cannot exceed 10 percent of the total expenses. (Thus, a person incurring $2,000 in expenses could pay a maximum of $200 for all cost sharing.)

5/ A nongroup policy, sometimes called an "individual policy," is a policy which covers one person or family rather than a policy including more than one (group policy).

A group health insurance policy could not exclude any preexisting conditions or require a waiting period before their coverage. A non-group contract could not exclude any preexisting conditions, except pregnancy, but could require a waiting period of up to 90 days after enrollment. Any policy providing coverage for a family must include all dependent unmarried children under age 22 and automatically cover any newborn (or adopted) children.

Employment Groups

A health insurance policy covering an employment group must meet these requirements:

(a) continue coverage for at least 31 days after termination of employment,

(b) offer terminated employees a reasonable opportunity to obtain a certified nongroup policy, and

(c) provide an annual open enrollment period to permit enrollment of employees who previously failed to elect coverage.

Group Practice Plans

The requirements described above would not apply specifically to comprehensive prepaid group practice plans, but special requirements would be developed that would be equivalent, on an actuarial and benefit basis, to the general requirements.

Allowage Exclusions

A certified health insurance policy may exclude payment for--

(1) services covered under workmen's compensation, Medicare, or the catastrophic proposal,

(2) services where there is no legal obligation to pay (e.g., VA services),

(3) routine physical examinations,

(4) cosmetic surgery,

(5) charges for outpatient psychiatric services exceeding $250 in a year, and

(6) charges by a hospital for interns and resident physicians' services to the extent they exceed actual cost.

A policy may also include payment for charges which are not "reasonably priced." While this is not further defined, the bill indicates a charge would always be considered reasonable if not higher than the allowable charge under Medicare or the proposed catastrophic program.

Benefit-Premium Ratios

With regard to certification, the Department would establish a reasonable ratio of the amount of benefits paid to the amount of premiums collected (similar to a retention ratio). In determining the ratio, consideration would be given to the profit or nonprofit nature of the carrier and the number of subscribers in a group. In evaluating the ratio for a particular carrier, consideration would be given to the average ratio for similar carriers offering certified policies.

For individual policies, the ratio would initially be based on the ratio established for the smallest groups, but could be modified.

The Department would periodically review the actual experience of carriers with certified policies in order to determine if the policy continues to meet the requirements for certification.

Antitrust Exemption for Pools

The bill would suspend the antitrust laws of the Federal Government, the States, and political subdivisions to permit insurers to enter into arrangements to establish insurance pools to offer certified health insurance to the public. (Various Federal and other laws now make certain pools illegal.) These pool arrangements must be approved in advance of operation by the Department of Health, Education, and Welfare.

Report

The Department would report to the Congress within 3 years after enactment of the bill on the availability of certified insurance, and the extent of coverage, in each State.

LONG BILL

The "Catastrophic Illness Insurance Act" was introduced by Senator Russell B. Long of Louisiana as S. 1416.

Its provisions are identical to Title XX (Catastrophic Health Insurance Program) included in the Catastrophic Health Insurance and Medical Assistance Reform Act, introduced by Senators Long and Ribicoff as S. 2513, discussed previously.

MEDICARE PROGRAM
STANDARDS FOR PROVIDERS OF SERVICES

In order to participate in the Medicare program, providers of services have to meet certain statutory requirements and other health and safety requirements established by the Department of Health, Education, and Welfare.

Hospitals

General hospitals must be licensed under State law, maintain clinical records for all patients, have by-laws for their medical staff, have every patient under the care of a physician, provide 24-hour nursing service, and have a utilization review plan in effect. They must also meet health and safety requirements regarding their physical environment and the operation of their facilities and services.1/

Hospitals accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association are deemed to meet all the conditions of participation (except utilization review) although the Department has authority to establish standards higher or more precise than those of these organizations.

Tuberculosis and psychiatric hospitals must meet the same requirements as general hospitals and must be accredited by the Joint Commission as well as meet special requirements for medical records and staffing.

Skilled Nursing Facilities

Skilled nursing facilities must be licensed under State law, must maintain clinical records for all patients, have established policies regarding patient care, have every patient under physician supervision, provide 24-hour nursing service, have established procedures for dispensing drugs, and have a utilization plan in effect. They must also have a transfer agreement with a hospital and meet health and safety requirements regarding their physical environment and the services they provide. They are specifically required to meet the provisions of the Life Safety Code of the National Fire Protection Association applicable

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1/ Nonparticipating hospitals may provide emergency services under Medicare and these hospitals must be licensed under State law and provide 24-hour nursing service.

to nursing homes which the Department holds to be appropriate. They must also cooperate in an effective program of independent medical evaluation and audit of their patients.

Home Health Agencies

Home health agencies must provide skilled nursing services and other therapeutic services, be licensed under State law, maintain clinical records for all patients, have established policies for their services, and meet additional health and safety requirements.

Providers of Outpatient Physical Therapy Services

These providers include participating hospitals, skilled nursing facilities, and home health agencies. Clinics, rehabilitation agencies, and public health agencies can also be providers of outpatient physical therapy services if they are licensed under State law, maintain clinical records for all patients, provide an adequate program of physical therapy services for outpatients, have established policies for their services, and meet additional health and safety requirements.

Independent Laboratories

Independent laboratories must be licensed under State law and meet health and safety requirements regarding the qualifications of their personnel, recordkeeping, and the operation of their equipment and facilities.

Physicians and Other Professionals

Physicians must be legally authorized to practice medicine or surgery by the State in which they provide their services. Chiropractors, dental surgeons, and podiatrists have to meet similar requirements with respect to their services.

Other Suppliers of Services

Suppliers of portable X-ray services must be licensed under State law, and must meet health and safety requirements relating to physician supervision, qualifications of personnel, and safety standards for their equipment. Suppliers of ambulance service have to meet safety requirements for their ambulances and have trained personnel.

All Institutional Providers

All institutional providers are required to have a written plan reflecting an operating budget and a capital expenditures budget for the next 3 accounting years.

Discrimination Prohibited

Participating hospitals, skilled nursing facilities, and home health agencies must comply with the requirements of Title VI of the Civil Rights Act of 1964, which prohibits discrimination based on race, color, or national origin.

ANNUAL REPORTS AND SPECIAL RELEASES

Items shown with a price are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (check, money order, or Superintendent of Documents coupons only). Unpriced items available from ORS Publications Staff.

Medical Care Costs and Price Background Book: 96 pp.

Released December 1973. Presents in summary form comprehensive data on medical care costs and prices in the United States. Subjects range from the cost of private health insurance to public benefit payments: from doctor's and dentist's fees to who pays them.

Selected State Data MEDICARE Fiscal Years 1968-71: 58 pp.

Released December 1972. Summarizes basic Medicare information for each State, the District of Columbia, and Puerto Rico; data on enrollment, amounts reimbursed, the providers of services, as well as some utilization data for hospitals and extended care facilities.

Size and Shape of the Medical Care Dollar 1972: 36 pp. $.35

A two-color chart book which presents in graphic form the background facts relating to the medical care dollar--who pays; what and how much is bought; for whom it is spent; and how and why it has grown. Released August 1973.

Compendium of National Health Expenditures Data: 89 pp. $1.50

Tables comprise all available data on health expenditures from 1929 to 1971. Released December 1972. The data cover not only direct consumer outlays for medical care and the proportion paid by private health insurance but also includes health outlays by public programs and by other sources of payment such as private health insurance, direct payments, and philanthropy.

Personal Health Care Expenditures By State, Volume 1: 151 pp. $2.40

Designed to assist State government officials, State and local planning agencies, and health researchers involved in the coordinated planning, organization, and delivery of medical care services at the State and local level. State data are presented for each public program by source of funds and type of expenditure for two fiscal years to provide some measure of the impact of Medicare and Medicaid.

Social Security Programs in the United States: 133 pp. $1.20

Brings together information through July 1973 on the historical development and present status of all the major income-maintenance programs in the United States and on the health insurance and medical assistance programs under the Social Security Act.

Current Social Security Research Reports

Number	*Publication*	*Price*
42	*Woman and Social Security: Law and Policy in Five Countries*, by Dalmer Hoskins and Lenore E. Bixby. 95 pp.	$0.75
41	*Community Hospitals: Inflation in the Pre-Medicare Period*, by Karen Davis and Richard W. Foster. 138 pp.	$1.25
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36	*Private Pension Plans in West Germany and France*, by Max Horlick and Alfred M. Skolnik. 78 pp.	$0.40
35	*Health Insurance Plans Other Than Blue Cross or Blue Shield Plans or Insurance Companies*, by Louis S. Reed and Maureen Dwyer. 119 pp.	$1.00
34	*Resources After Retirement*, by Edna C. Wentworth and Dena K. Motley. 88 pp.	$0.45
33	*Public Attitudes Toward Social Security, 1935–1965*, by Michael E. Schiltz. 231 pp.	$1.00
32	*The Benefit Structure of Private Health Insurance, 1968*, by Louis S. Reed and Willine Carr. 111 pp.	$1.00

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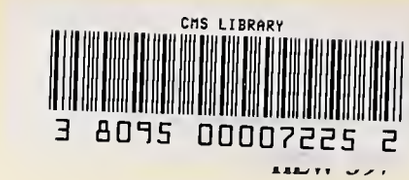

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